RED HILLS
DENTAL ASSOCIATES

1957 Raymond Diehl Rd. • Tallahassee, FL 32308 • (850) 385-2003

Patient Name:_____ **DOB:**_____

Our office vision is to deliver the highest quality dental care to our patients in a safe and caring environment. We are a friendly, productive team that provides a nurturing and stimulating atmosphere for you, our patients. With this in mind, we realize that each patient's financial situation is unique. For this reason we have worked hard to provide a variety of flexible payment options to help you receive and enjoy a healthy and confident smile.
If you have dental insurance, we are here to help you receive your maximum allowable benefit. In order to accomplish this, we will need to inform you of our financial policy.

Payment for dental treatment is due at the time services are rendered. Prior approval is required for payment arrangements before the start of any dental treatment. We accept CASH, CHECKS, MASTERCARD, VISA, AMEX, DISCOVER, CARE CREDIT, & CITI FINANCIAL. As a courtesy to our insured patients we will file your insurance for you and accept the assignment of benefits, but any co-payment or deductible is due at time of service.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to the contract.

2. Our fees are generally considered to fall within the acceptable range of cost of care by most companies, and therefore are covered up to the maximum allowance determined by each insurance carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R.". "U.C.R." is defined as usual, customary and reasonable fees for this region. Our fees are considered usual, customary and reasonable by most companies in this area. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears absolutely no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. We will do our best, as a free service, to inform you of your contracts benefits but, due to the thousands of insurance contracts available it is ultimately the patient's responsibility to be aware of the particular contract provisions and we will not be held liable for items not covered in an individual's contract.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility on the date the services are rendered. If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

We ask that you give us 48 hours' notice for any appointment change, so that the appointment may be offered to someone else in need. Please remember that your appointment time reserves a clinical treatment room and dental support staff needed to complete your dental visit. Broken appointments and appointments canceled without 48 hours' notice may incur a $75 broken appointment fee. Returned checks are subject to a $30 collection fee. Delinquent accounts sent to a collection agency may be assessed additional collection and/or attorney's fees and will be the responsibility of the responsible party listed on the account.

By signing below, you authorize release of any information relating to your insurance claim, as well as payment directly to us by your group insurance benefits. In addition, you agree that any balance not paid in full either by you, your insurance company, or without prior arrangements, is considered due and must be paid by you.

_____ _____

Patient/Guardian Signature Date

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NOTICE OF HIPAA PRIVACY ACT
RECORDS RELEASE INFORMATION

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.**
- **Obtain payment from third-party payers**
- **Conduct normal healthcare operations such as quality assessments and physician certifications.**

_____
Patient Name (Print)

_____
Signature **Date**

I hereby authorize the office of Lawrence E. Weaver, DDS, to use and disclose in any form or format a copy of my records for dental purposes only.
You may release my information to the following: (check all that apply)

☐ **Spouse** ☐ **Medical Doctor** ☐ **Parents** ☐ **other: (specify)**

_____

_____
Patient Name: (Print) **DOB**

_____
Patient/Guardian Signature **Date**