**OFFICE FINANCIAL POLICY**

Insurance eligibility and benefits will be verified at the time of your visit.

We do not accept any HMO.

You will be responsible for any services not covered by your plan.

Your treatment plan will be discussed following your consultation. We will discuss deposits due and financial arrangements. If all or part of your treatment is not covered by your plan the non covered portion is due in full prior to your treatment date.

At your request we will file a pre-determination of benefits to your insurance company. Please allow 2-6 weeks for a reply. *Please note that pre-determinations are only ESTIMATES and no guarantee of payment can be made by Charlotte Oral Surgery and Implant Center or your insurance company.*

If a pre-determination is not received prior to your requested surgery date, a 50% deposit will be required at the time of service.

Some insurance companies that we are not in contract with will reimburse the patient directly. In these cases, we will collect payment in full at the time of service and will file your claim on your behalf as a courtesy.

As a courtesy Charlotte Oral Surgery and Implant Center will file all claims to your insurance on your behalf. It is your responsibility to follow up with your insurance company regarding payments not received within 60 days.

Payment is due within 60 days of the date of service. You will receive monthly statements as a reminder to follow up with your insurance company.

In the event of an overpayment, a refund will be issued to the PATIENT or GUARANTOR.

I have read and understand the terms of this policy:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient / Guarantor Date

**HIPAA OMNIBUS RULE**

**PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

**AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM**

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

**MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Representative / Guardian Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

🞎 First Name Only 🞎 Proper Sir Name 🞎 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient’s records):

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

🞎 Cell Phone Confirmation 🞎 Home Phone Confirmation 🞎 Email Confirmation

🞎 Work Phone Confirmation 🞎 **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

🞎 Cell Phone Confirmation 🞎 Home Phone Confirmation 🞎 Email Confirmation

🞎 Work Phone Confirmation 🞎 **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

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**Office Use Only**

As Privacy Officer, I attempted to obtain the patient’s (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment \_\_\_\_\_

I could not communicate with the patient \_\_\_\_\_

The patient refused to sign \_\_\_\_\_

The patient was unable to sign because \_\_\_\_\_

Other (please describe) \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Privacy Officer