Coastal Dental Associates
Office Policies

Our office is open for patient care from 8:00am-5:00pm with a closed 1 hour lunch break from 1:00pm-2:00pm.

INSURANCE AND FINANCIAL POLICY

Our goal in discussing financial arrangements relative to your dental needs includes:

- All Dental Insurance information must be provided to the office prior to our patients upcoming visits. You can call/text or email the information directly to the office : Call/Text 603-436-6997 Email: info@coastaldentalassoc.com
- Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.
- Please understand that the amount of benefits to be derived under your particular policy is a predetermined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which your insurance agreement allows. However, this should not have control over what is in your best interest as far as treatment is concerned.
- For your convenience, we will estimate the portion of the fee that your insurance company will not cover. This is just an estimate. After your insurance benefits have been paid, you are responsible for any unpaid balance. We will ask you to bring with you at the time of treatment the estimated uncovered portion of the total fee. It is not possible to know exactly what your insurance coverage will be prior to treatment, as treatment sometimes changes. Insurance companies do want any treatment over $300 to have a pre-determination done.
- Should collections become necessary, the responsible party agrees to pay all legal fees of collection, with or without suit, including mediation, attorney fees and court costs.
- Our policy requires the estimated out-of-pocket portion to be paid at the time of your treatment. Full payment is required at the time of service if you are not covered by a dental plan or you have chosen option 1 in our patient options;.
- I certify that I am covered by the Insurance Co. provided above and I hereby authorize the dentist to release all information necessary to secure the payment of benefit, including the right to appeal. I understand that I am financially responsible for all charges for services rendered whether or not paid by insurance. Initial: _____

HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.

I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers or vendors involved in my treatment).
- Obtaining payment from third party payers (e.g. my insurance company).
- The day-to-day healthcare operations of your practice. Initial: _____

PHOTOGRAPHY CONSENT

- I hereby authorize and consent to the use of certain photographs and/or x-rays taken by Coastal Dental Associates. Photographs taken during treatment are used by our laboratories for cosmetic purposes for the fabrication of your crowns, bridges or dentures and are a part of your permanent dental record.
- I hereby grant them permission to reproduce, publish, print, use, and distribute copies of such photographs/x-rays either in an official medical publication, or in the form of prints, slides or film for use in connection with articles and lectures dealing with dental or medical content. I specifically waive any claim for invasion of my personal privacy, which might occur to me on account of the use of such pictures without my express consent in each instance. Initial: _____

APPOINTMENTS:

- Your dental appointment is considered confirmed at the time of booking. This means we are **reserving** time with our doctor, assistant and hygienist, as well as the treatment room as required. We will be sterilizing and preparing the room as well as all the equipment and materials required for your procedure. We therefore request that if you are unable to attend the scheduled appointment you contact our office with 48 hours notice to reschedule. There will be a $60 fee assessed for every appointment missed or canceled within 48 hours notice. As a courtesy we will telephone/email/text you prior to your appointment to remind you of the appointment you have booked. Initial: _____

COMMUNICATIONS:

- I, _____], hereby consent to receive electronic communications from CDA at the email address/Phone number provided. I understand that these communications may include appointment reminders, treatment updates, and billing information. I can withdraw my consent to receive electronic communications at any time by contacting the office at 603-436-6997

PAYMENT OPTIONS

Option 1: Payment is due in full at the time of service. We accept Visa, MasterCard, Debit, Cash and HSA/FSA.
Your payment will be processed and we will submit your dental claim to your insurance carrier, on your behalf. Your insurance carrier will reimburse you via your chosen payment method (direct deposit or check).

Option 2: Assignment of Benefits: Your insurance carrier must allow 'Assignment of Benefits.' We will submit your dental claim to your insurance carrier on your behalf, and you will be responsible for the remaining portion not covered through your insurance. A valid credit card MUST remain on file. This includes dual insurance holders. It is your responsibility to notify Coastal Dental Associates of any changes which affect your credit card account. Your account must remain in 'good standing' and any outstanding/uncollectible balance for more than 60 days will no longer be considered eligible for Direct Billing services offered.

I, _____ authorize Coastal Dental Associates to keep my signature on file and to issue a credit or debit memo to my credit card account for any over and under payment once my insurance portion has been received. I will be notified by telephone/Text if my account is charged or credited within an excess of $150. I give my permission for any claim not paid by my insurance company for myself and any minor family member listed below to be automatically charged to my credit card. A receipt for this transaction will be sent to you via text/email. If using FSA/HSA please note below and a detailed receipt will be emailed to: _____(email address)

If you do not wish to leave a credit card number on file, Option 1 is your only choice.

REGARDING DENTAL BENEFITS (INSURANCE)

We must emphasize that as your dental care provider, our relationship is with **you, our patient**, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. We will provide an insurance estimate to you; however,per your dental insurance plan **Pre-certifications are not a guarantee of payment** .Your estimated insurance benefit may differ due to a number of reasons, specifically related to your Dental Insurance Plan. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Your insurance company and your plan benefits ultimately determine the amount paid. All charges you incur are your responsibility, regardless of your insurance coverage.
Coastal Dental Associates does not presume to act as a representative of your insurance carrier.

A yearly oral evaluation performed by one of our Dentists is mandatory as we follow the ADA requirements and recommendations.

Our office encourages you to contact your previous dental office for any and all dental records to be emailed to our office. Our office does require all patients to have a current full mouth series of x-rays on file. We will be happy to accept current and past x-rays films from your previous dental office however we must receive films **prior to your New Patient Evaluation Visit.** Panoramic x-rays OR Full mouth series will be taken every three - five years to evaluate bone health and provide a thorough diagnosis. Bitewing x-rays will be taken annually to detect interproximal decay.

The team at Coastal Dental Associates strives to help our patients improve the quality of their lives by providing the highest standard of dental care possible, including uncompromising personalized service with meticulous attention to the individual needs of our patients, their families, with a commitment to caring and respecting every person we have the privilege to serve.

MINOR PATIENTS

• The parent who brings the child to his/her appointment will be financially responsible for any balances, co- payments and fees.

I have read, understand and agree to abide by these terms of these Payment, Insurance and Appointment practices:

Printed Name of Patient or Responsible Party_____

Signature of Patient or Responsible Party _____

Date _____