COCHISE CHILDREN'S DENTAL CENTER
MORGAN EVERSHED, DDS
PEDIATRIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.

I, _____ have received a copy of this office's Privacy Practices.

Name (please print) _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

__ Individual refused to sign

__ Communication barriers prohibited obtaining the acknowledgement

__ An emergency situation prevented us from obtaining the acknowledgement

__ Other (please specify)

_____

2273 E. WILCOX DRIVE SIERRA VISTA, ARIZONA 85635 (520) 458-1835

COCHISE CHILDREN'S DENTAL CENTER
MORGAN EVERSHED, DDS
PEDIATRIC DENTISTRY

FINANCIAL POLICY

We are committed to providing your child(ren) with the best possible care. Feel free to discuss any questions you may have about our fees, financial policy or your responsibility with our staff at any time. Please notify us at least 48 hours in advance to avoid broken appointment charges if you are unable to keep your scheduled appointment.

OUR POLICY IS THAT TREATMENT WILL BE PAID FOR AT THE TIME OF SERVICE. The Parent or Guardian who accompanies the child is responsible for payment at time of service. We accept cash, checks, MasterCard, Visa, Discover and American Express. *Please note that* our office does not provide a billings service, however, for those desiring a payment plan, we offer several options through a third party, Care Credit.

TREATMENT PLAN ESTIMATE: At the time of each new patient exam or recall exam, you will receive an estimate of treatment costs and your expected co-payment. If you require an exact statement of co-payment from your insurance company, we can submit a request for a pre-determination of benefits for you. However, this may delay treatment. The costs listed are an estimate only and may need to be revised if changes occur in the dental health of your child(ren). If changes are needed, you will be informed before that treatment is rendered. Estimated costs are valid for treatment completed within 90 days of the estimate.

DENTAL INSURANCE: If you have insurance we will help you receive maximum benefits, however, your child(ren)'s treatment plan(s) are based on the treatment needs of the child(ren), **NOT** on what your insurance will pay for. As an example, children who have a history of numerous cavities may need cavity detecting x-rays (BWX) every six months, even though many insurance companies only pay for this service once every twelve months.

As a courtesy to you, our office accepts assignment of benefits for the portion of the fee that we would expect the insurance company to pay. This courtesy is extended to those patients whose insurance company will pay directly to us. You are responsible to pay the patient's co-payment at the time of service. If your insurance company has not paid the full balance within 45 days of claim submission, you are responsible for paying the balance within fifteen (15) days of notification. We will notify you if your insurance company has not paid us within 45 days. If your insurance company pays more than the balance due we will send a refund check to you immediately.

Dental insurance is a contract between you/your employer and the insurance company. We are **NOT** a party to this contract. We file insurance claims as a courtesy to you our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, etc., other than to provide factual information as necessary. Ultimately, you are responsible for the timely payment of your account.

Name (please print) _____

Signature _____ Date _____

2273 E. WILCOX DRIVE SIERRA VISTA, ARIZONA 85635 (520) 458-1835