Dental Health Agreement

Thank you for selecting our office for your dental care. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.
In order to be impartial to everyone, **WE REQUIRE PAYMENT AT TIME OF TREATMENT.** We ask that you read and sign this statement prior to any treatment. **YOUR PATIENT PORTION IS DUE IN FULL AT THE TIME OF THE TREATMENT.** For extensive treatment plans, we offer extended payment plans with an outside financial institution at either little or NO interest with prior credit approval.

REGARDING INSURANCE

We will gladly file all dental claims for given treatment but **WE ARE NOT A PARTY TO ANY INSURANCE PROGRAMS OR CONTRACTS. The balance is YOUR responsibility whether your insurance company pays for your treatment or not. It is not easy for our office to become familiar with the details of every dental plan we encounter. The patient, not the dental office, is responsible for knowing what is covered and what is excluded from her or his dental plan. It is your responsibility to inform us of any changes in your insurance coverage.** We will track your insurance claims for **60 days**, then it is **YOUR** responsibility and the balance will be due even if your insurance company has not paid their portion.

MISSED APPOINTMENTS

In order to be fair to all of our patients, we ask that you notify our office at least **24 hours** in advance if you can not keep your appointment. There will be a **CHARGE OF $70 FOR EACH MISSED APPOINTMENT.**

FINANCE CHARGES AND COLLECTION FEES

There is a **1.5% monthly late charge** assessed on all balances **after 60 days past due. Checks** which are declared **non-sufficient funds** will be **charged a $25.00 service fee.**

I understand that if my account reaches *collection status* and I make no effort to pay off my account, my account will be assigned to a *collection attorney or agency*. If Dr. Monroe must take additional steps to collect my account, *I agree to pay a collection fee of 50% of the total owed when sent to collection, all attorney fees, and court costs incurred by Dr. Monroe.*

Thank you for taking the time to read and understand our financial agreement. Our practice is committed to providing the best treatment for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

All the information provided is correct.
I have read and understand the above information in its entirety.

Date_____ Patient/Guardian Signature_____

Date_____ Approved by_____

Edward J. Monroe, D.D.S.
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LaSalle, IL 61301
Phone (815)223-6013
Fax (815)223-1128

334 Backbone Road E
Princeton, IL 61356
Phone (815)875-1183
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HIPAA CONSENT FORM

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). 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 involved in my treatment);
> Obtaining payment from third party payers (eg: my insurance company);
> The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date: _____

Print Patient Name: _____

Patient/Guardian Signature: _____

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