Financial Policy, Cooper Owens

Payment: Payment is due at time services are rendered. We accept the following forms of payment: cash, check , Mastercard, Visa, American Express and Care Credit. You are more than welcome to leave your credit card on file to be run for outstanding balances. Without that on file, outstanding balances will be subject to billing/finance charges. Delinquent accounts will be responsible for all collection processing fees and attorney fees.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental plan. Benefits and payments received are based on the terms of the contract negotiated. We are happy to help our patients with dental benefit plans to understand their coverage, but we cannot guarantee the accuracy of information from the insurance company or any changes regarding the contract.

If we are contracted provider with your plan, you are responsible for the approved fee as determined by your plan. We are required to collect the patient's estimate portion (deductible, co-insurance, copay or any amount not covered by the dental benefit plan)**in full** at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this and you will be responsible for the difference.

If we are not a contracted provider with your dental plan, it is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out of network providers. If your plan allows reimbursement for services, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan, even if that amount is different than our estimated patient portion of the bill. If you choose not to "assign benefits" to our practice, you are responsible for filing the claim and obtaining reimbursement and will be responsible for payment in full to our practice before, or oat the time of service.

Scheduled appointments: We reserve time in our schedule for each patient procedures so when a patient cancels an appointment, it impacts the number of patients we are able to care for each day. To maintain the utmost service for all our patients, we do require 48 hours notice to cancel, change or reschedule an appointment. With less than 48 hours notice, a fee will be charged. The fee is $100.00 dollars an hour for scheduled doctor appointments and $50.00 for scheduled hygiene appointments. If there are more than two short cancellations within 12 months, we will no longer be able to reserve an advanced appointment for you. We do understand that emergencies arise and ask for you to notify us asap.

HIPAA: By signing below you understand that under HIPAA you have certain rights to privacy regarding your protected health info.

Authorizations: I authorize the team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment discussions. I authorize release of information necessary to be made directly to Cooper Owens DDS for services rendered to me.

Signature of responsible party _____ Date_____

Print Name _____