



RINEHART DENTAL
Damion G. Williams, DMD
COSMETIC AND FAMILY DENTIST

Hippa

Health Insurance Portability and Accountability Act

We will be using your health insurance information for payment. A claim may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

RELEASE OF CONFIDENTIAL INFORMATION

Initials THIS IS TO INFORM YOU THAT DUE TO FEDERAL LAW (HIPPA), EFFECTIVE APRIL 14, 2003, WE MAY ONLY RELEASE MEDICAL INFORMATION TO THE FOLLOWING:

1. HEALTHCARE PROVIDERS INVOLVED IN YOUR CARE.
2. INSURANCE COMPANIES TO SECURE PAYMENT.
3. ATTORNEYS WITH YOUR PERMISSION.
4. PATIENT'S LEGAL REPRESENTATIVE.

Initials APPOINTMENT REMINDERS AND ANY DENTAL TREATMENT MAY BE CALLED TO: **(PLEASE CHECK ALL THAT APPLY)**

_____ HOME/ANSWERING MACHINE _____ CELL
_____ OFFICE/VOICEMAIL _____ OTHER

Initials A COPY OF RINEHART DENTAL "NOTICE OF PRIVACY PRACTICE" IS AVAILABLE FOR YOUR REVIEW.

Financial Policy

Thank you for choosing Rinehart Dental, as your dental care provider. Please read this financial policy thoroughly. Due to the constant changes and demands of healthcare plans we ask for your cooperation in providing the following:

- ❖ Your current and correct insurance information (**copy of insurance card**)
- ❖ Copy of picture **ID**

Initials Your co-pay, cost of treatment, lab fee and/or deductibles are expected to be paid on the **1st day of service** even if you are due back for crown, bridges, veneers, lumineers, invisalign, dentures or any other dental treatment final fitting. **You may reschedule if you cannot pay your co-pay or any outstanding balances from a previous visit that is solely your responsibility.**

Initials All cobra, self pay and non-participating insurance (or plan that cannot be verified at your time of visit) patients must pay in full at the time of visit. You can file your receipt from us to try and seek reimbursement. We cannot file those claims for you.

Initials I hereby assign all insurance benefits to which I am entitled, including HMO, DMO, private insurance, major dental benefits and any other health plans to the assigned dentist (Dr. Damion Williams). The assignment will remain in effect until revoked by me in writing. I hereby authorize to release all information which may be found in my dental record and is necessary to secure payment.

Initials We will file your claims as a courtesy. If your health plan fails to pay your claims in a timely manner, **you will be responsible for the balance and contacting your insurance provider to follow up.** We will send you a statement notifying you of the circumstance. **Please do not ignore these statements.** If we fail to resolve any outstanding balances with you it could result in your account going to collections or you will be reported to the credit rating bureaus. Rinehart Dental will work with you, but we also need your help since this is your policy with your insurance company. Thank you for understanding.

Initials I understand that that Rinehart Dental currently charges \$25.00 for a broken or cancelled appointment, and this fee is subject to change with notice. Please we would like 24HR notice.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY SAID INSURANCE.

PATIENT OR RESPONSIBLE PARTY _____

Signature

Date

**PLEASE HAVE YOUR INSURANCE CARD AND PICTURE ID READY FOR THE RECEPTIONIST TO MAKE A COPY.
THANK YOU**