McDonald Family Dentistry Patient Policies

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed unless other arrangements are made.
Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for the payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of the treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for the services shall be billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach or any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.
I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Services Consent and Financial Policy. *

Appointment Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 BUSINESS HOURS in advance. Our office is open Monday-Thursday, 8:00am-5:00pm. We do not accept cancellations by phone calls/voicemail on days that our office is closed.
Dr. McDonald and our hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. There may be a a fee of $50.00 assessed if we do not receive a cancellation request prior to 24 BUSINESS HOURS of the scheduled appointment time.
Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointment times to better serve the needs of all patients.

☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Appointment Policy. *

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have

signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s):
(Please enter the name and relationship to the patient.)

Name(s):
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☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form. *

Patient Signature

E-Signature (draw, upload or type) (ESign)

Date :