Green Valley Dentistry

As health care providers we must emphasize that our relationship is with you and NOT the insurance companies. Our role is to assist you with filing your claims. While we do our best to work within your insurance limit and/or inform you of services not covered by your insurance plan; our main concern is to recommend treatment based upon your individual dental needs. We do NOT base recommendations and/or treatments on only what your insurance will cover.

1. If you have private insurance plans, we will accept assignment of your insurance benefits. However, your copayment (share of cost), deductible and any charges not covered by your insurance are your responsibility.
2. Your insurance policy is a contract between you, your employer and the insurance company. Informing you of your benefits and filing of your claims is a routine courtesy that we extend to our patients. **Knowing your insurance benefits and limitations and/or restrictions is your responsibility.** We strive to provide you with accurate **estimates** of your share of cost based on the information provided from your insurance carrier. However, acceptance of insurance does not absolve the patients of full responsibility for the charges for the treatment rendered. The approximate insurance payment is to be a guideline until the final insurance payment is received an the account has been reconciled. This office cannot guarantee the insurance payment as estimated.
3. A finance charge of 1.5% per month will be applied to any balance over 90 days.
4. We understand that our lives are hectic, and with that, we overlook our appointments. If it is necessary to cancel or reschedule an appointment, please do so at least 24 hours prior to you scheduled appointment time. **Missed or cancelled appointments without a 24 hour notice will be charged a minimum fee of $40 per hour.** Your fee must be paid before your next scheduled appointment.
5. For your convenience, we accept cash, personal checks, Visa, MasterCard and Discover.

I have read and agree to these guidelines.

Patient name (print)_____
(Patient, Parent, Guardian or Personal Representative)

Signature_____ Date_____
(Patient, Parent, Guardian or Personal Representative)

Acknowledgement of Receipt of Notice of Privacy Practices
**you may refuse to sign this Privacy acknowledgement*

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

Please Print Name_____

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
___ Communications barriers prohibited obtaining the acknowledgement
___ An emergency prevented us from obtaining acknowledgement
___ Other *Please specify*_____