FINANCIAL POLICY

Payment

Payment is expected at the time of treatment.
You may pay for your treatment by:

- Cash or check
- VISA/Master Card
- American Express
- Discover

Payment plans available

Insurance

You, as the parent, are financially responsible for all fees pertaining to your child. We do accept many insurance plans, but you must be aware that insurance companies rarely pay the full fee for any service. You will be expected to pay the difference between our fee and your insurance company's estimated payment on the day treatment is received. If the insurance company pays a lower amount than shown on your estimate, you will receive a bill for the remaining balance. If your insurance company pays more than the estimated amount, you will receive a refund for any amount you overpaid.

The estimate that you receive in our office is based upon information we receive from your insurance company at the time of insurance verification, as well as the actual payment record of your insurance company for specific procedures in this office. We strive to make this estimate as close as possible to the actual amount your insurance company will pay, so that you will have an accurate idea of what you are expected to pay after insurance has been applied. However, any differences between our estimate and the actual insurance payments are still the responsibility of the parent. We do not "write off" the difference between our full fee and whatever insurance may pay.

Missed or No Show Appointment Policy

We understand that emergencies and that unforeseen things happen, and occasionally you will need to reschedule an appointment. We request that you give us a 24 hour notice for cancellation of an appointment. This allows us to reschedule your appointment and let another patient have the time originally reserved for your child. If 2 broken/ missed appointments occur or 2 cancellations occur without at least a 24 hour notice, we reserve the right NOT to schedule any subsequent appointments. We also reserve the right to charge a cancellation fee of $50.

I acknowledge I have read this financial policy and I am responsible for all charges whether or not paid by insurance.

Please list all children

_____ _____ _____

_____ _____ _____

Name of Parent/Guardian: _____ Relationship to patient: _____

_____ Date: _____/_____/_____

Signature of Parent or Guardian

Turn Page

Tina H. Bui, DDS, MS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGMENT*****

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

_____
{Print Name}

_____ _____
{Signature} {Date}

Please list all children.

_____ _____

_____ _____

_____ _____

REQUEST FOR RELEASE OF RECORDS

I hereby give my permission to release all records and x-rays to insurance companies, or other health practitioners upon request. If records are sent via e-mail, I understand they may be unsecured.

_____ _____
{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:

- o Individual refused to sign
- o Date_____ Name of Individual _____ Initials _____
- o Communications barriers prohibited obtaining the acknowledgment
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (please specify)_____