Seaport Family Dentistry

www.seaportdentistry.com info@seaportdentistry.com
2 Westwoods Drive • Liberty, MO 64068 (816)781-1430

Financial Policy

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon payment from patients for the costs incurred in their care. Financial responsibility must be determined before treatment is administered. All emergency dental services and any dental services performed without previous financial arrangements must be paid at the time services are rendered.

INSURANCE:
We may accept assignment of insurance benefits.
If we accept such assignment, we require that your portion of the bill be paid at the time of service.
The balance of your bill is your responsibility whether your insurance carrier pays or not. If your insurance carrier does not pay within a reasonable amount of time (90 days) from the time of service, we may collect the balance directly from you.
We file your insurance for you as a courtesy, but your insurance is a contract between you and your company. We are not a part of that contract.
We reserve the right to add a 2% service fee (up to 20% APR) to balances over 90 days.

MISSED APPOINTMENTS:
We ask that if you cannot make your appointment that you cancel 24 hours before the appointment.
We reserve the right to charge $50.00 for EACH missed appointment.

FORMS OF PAYMENT ACCEPTED:
Cash, Checks and all major Credit Cards.
Subject to approval, we may be able to offer extended payment options through Lending Point and Care Credit.

I hereby give consent for all treatment related to my oral healthcare, which include but not limited to, routine preventative care, scheduled treatment and emergency. I grant my permission to you and your assignee, to telephone or email me to discuss matters related to my patient forms as well as the financial policy. I understand that I am responsible for any collection and/or attorney fees that may incur if the account is not paid in full.

☐ ***I have read, understand and agree with the foregoing Financial Policy.**

Signature of guarantor of payment/responsible party (Must be 18 years of age):

Signature ______________________________ **Date** ____________

Relationship to Patient: *

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Emergency Contact:

In an emergency who should be notified? Please enter Name and Phone number below:
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HIPPA 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 received 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 health care 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.

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

Here is a list of who you may share my information with and their relationship to me:

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Consent for Internet Communications

I grant my permission to the dental practice to upload and store patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any authorized use of my ID or any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ ***I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site**

Response Date: ____________