Kimberly G. Redick, DMD

FINANCIAL POLICY

We look forward to serving you and your family. We value your oral health and well- being and promise to give you our best always. We feel privileged that you have selected us to care for you.

The following Financial Policy is required prior to any dental treatment. Please understand we do not want to see financial constraints and/or broken appointments interfere with dental care and the doctor/patient relationship. To facilitate your payments, the following options are listed. Please read them carefully, **initial**, and **sign** all the designated lines.

PAYMENT OPTIONS

- **IF YOU DO NOT HAVE INSURANCE,** payment is due in full at the time treatment is provided. For your convenience, we accept cash, personal checks, MasterCard, Visa, and debit cards. Accounts over 90 days will be subject to service/and or finance charges. **INITIAL____**
- **IF YOU HAVE INSURANCE,** we will submit your insurance claim to your insurance carrier as a courtesy to you. The amount of coverage paid by your insurance company may be based on your insurance company's usual and customary rates and/or fee schedule. Please note that all estimates are as stated **(estimate only)** and therefore we cannot guarantee them to be exact. You are responsible at the time of your appointment for any deductible or co-payment not covered by your insurance company, as well as any remaining balance that the insurance company fails to pay. If your insurance company does not remit payment within 60 days, the balance will be due from you and may be subject to service/ and or finance charges. **INITIAL_____**
- **I UNDERSTAND** that if my account becomes past due and has to be turned over to a third party agency, there will be a fee of 35% added to my balance. **INITIAL_____**
- **BROKEN APPOINTMENT POLICY** Appointments in our office are reserved exclusively for each patient and are also customized according to individual needs. **For this reason, we ask for confirmation on ALL appointments, if you are unable to keep your reserved appointment, please give us at least 24 hours' notice.** If you have a Monday appointment and need to cancel or reschedule, you need to contact our office no later than Thursday, the week before (please leave a message). We charge $40 per hour scheduled for all broken appointments, no shows, and rescheduled appointments if less than 24 hours is given. **INITIAL_____**

RETURNED CHECKS

- There will be a $25 returned check fee applied to your account id a check is returned. The account then must be paid by CASH, MASTERCARD, OR VISA. **INITIAL_____**

Attached below are authorizations required for filing your insurance on your behalf. Please review and sign where indicated.

AUTHORIZATION OF ASSIGNMENT OF BENEFITS

I authorize **Dr. Redick** to bill my insurance company directly for service and direct payment of benefits to **Dr. Redick** that otherwise would be payable by me.

AUTHORIZATION TO RECEIVE OR RELEASE MEDICAL INFORMATION

I authorize **Dr. Redick** to release all medical/dental information to my insurance carriers or other third party payers as may be required or requested for the processing of claims.

AUTHORIZATION OF SIGNATURE ON FILE

I authorize use of this form on ALL my insurance submissions. I authorize release of information to all my insurance companies. I understand that I am ultimately responsible for my account balance. I authorize **Dr. Redick** to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to **Dr. Redick**. I permit a copy of this authorization to be used in the place of the original.

Patient Printed Name **Patient/Responsible Party Signature** **Date**

PATIENT CONSENT TO TREATMENT

I hereby authorize Dr. Kimberly Redick/Dr. Andrew Abbott to treat me or the person under my legal care with the following dental procedures if or when needed: prophylaxis (dental cleaning), dental radiographs, delivery of local anesthesia, restorations (fillings), crowns, fixed partial dentures (bridges), implant restorations, full or partial dentures, cosmetic dentistry, extractions (tooth removal), non-surgical or surgical treatment of the periodontal tissues, biopsy, root canal therapy, or any other treatment deemed necessary for my complete oral health and well being.

Dr. Redick/ Dr. Abbott has fully explained to me the nature and purpose of the above procedures and has also explained the benefits and potential risks from known and unknown causes of the treatment. I have been given alternatives to the treatment, the risks and the benefits of the alternative treatments, and the consequences of having treatment withheld. I have been given the opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

I understand that during treatment unforeseen conditions may arise that would justify altering the proposed plan of treatment. I, therefore, consent to the performance of any additional treatment which the dentist considers necessary.

I consent to the use of topical and local anesthetic. I understand that certain risks are associated with the injection of anesthesia. These risks include but are not limited to bruising or injury to blood vessels, swelling, fainting, dizziness, tachycardia, soreness at injection site, infection, and temporary or permanent nerve injury resulting in pain, prolonged numbness or parathesia, and tingling in the effected areas.

I consent to the use of antibiotics and analgesics. I understand that with any medication risk and side effects are possible. These risks include but are not limited to drug interaction, allergic reaction, and any side effect listed by the drug manufacturer.

I have been given no assurances or guarantees as to the outcome of the treatment. I realize that inspite of the possible complications my proposed treatment is necessary and desired by me.

I understand that it is vital that I give as accurate and complete a medical history as possible. I understand that if any part of my medical history alerts Dr. Redick/ Dr. Abbott that I am at risk of endocarditis or joint replacement or implant infection I must take antibiotics prior to any dental treatment.

I confirm that I have ready and fully understand all of the information provided above.

Signature _____ Date _____
(Patient or Guardian)
Print Name of Patient _____
Relationship to Patient _____

Signature of Dentist _____ Date _____

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AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient name(s): _____

_____

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Detailed description of the information to be released: ***Information pertaining to treatment for referral purposes, or information as required for processing insurance claims.***
2. To whom may the information be released [name(s) or class(es) of recipients]: ***Insurance companies and/or referring providers.***
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. It is our policy to not release your information other than as stated in this authorization. Sometimes, state or federal law changes this possibility.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Dated_____ Patient signature_____

If you are signing as a personal representative of the patient, describe to the patient and the source of your authority to sign this form:

Relationship to the patient _____ Print Name_____

Source of Authority_____

---------- tear here ----------

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Redicks' Notice of Privacy Practices.

Patient name (s) : _____

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Signature _____ Date _____