OFFICE FINANCIAL POLICY

1. It is the intent of this office to ASSIST you with your insurance benefit information. The only medical plans we participate with are Horizon, Amerihealth, Personal Choice and Keystone. The only dental plans we participate with are Delta Dental, Horizon traditional plan and Cigna Dental PPO (radius network).
2. We are NOT responsible for ANY information provided to us as a courtesy to you by your insurance company.
3. It is difficult to obtain reliable financial information from insurance companies regarding oral surgery procedures. **Contract allowances have many conditions for eligibility established by the insurance carrier not based on need** for the service. These conditions for eligibility continually change and we are not apprised of the changes.

Treatment Fee and Payment:

- Payment is expected at time of treatment.
- Financial arrangements can be made in **advance** of your appointment.
- Estimated payments are due at the time of your appointment.
- Pretreatment estimates can be submitted to your insurance company so that they can provide you with financial information regarding the amount they will or will not pay towards the above treatment. Any quotes are ESTIMATES only. We will do our best to help you with insurance information from your insurance company.

I understand that ESTIMATES of insurance benefits for services performed both verbal and written are only ESTIMATES. I understand this office attempts to obtain information about YOUR BENEFITS as a courtesy to you. I understand that ***any information this office provides you regarding benefit coverage is not a guarantee in any respect that the insurance company will pay this amount. I will not hold this office responsible for benefit information obtained on MY behalf. The information may not be accurate. Ultimately, this information is your responsibility, we are only assisting you.***

I understand that my dental or medical insurance carrier may pay less than the actual fee and/or estimate for services provided in writing and verbally. ALL estimates are nonbinding. I agree to be responsible for payment of all services rendered on my behalf or my dependents. A service charge of 1.5% per month will be charged on all unpaid balances over 60 days. There will be a service charge of $25.00 for all returned checks. If my account is turned over to a collection agency I will be responsible to pay an administrative fee of $50.00. If you have paid a deposit for your procedure and cancel less than 48 hours before the appointment, you forfeit your deposit.

- I authorize Dr. Rebhun to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and /or other health practitioners.
- I assign and request my insurance company to pay directly to Donald G. Rebhun, D.M.D. benefits otherwise payable to me.

All balances are due in full 90 days after treatment **regardless of insurances intent to pay.**

I have read and understand the above entirely.

Signature Guarantor:_____Date:_____

Print Name Clearly:_____

PATIENT DISCLOSURE INSTRUCTIONS

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (*check all that apply*):

☐ Home Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to number indicated

☐ Work Telephone _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other (Fax/Cell, etc.) _____

_____

I allow you to give my clinical information to or answer questions from (*check all that apply*):

- ☐ Spouse
- ☐ Parent
- ☐ Child
- ☐ Other (specify): _____
- ☐ None

_____ _____

Patient Signature Date

_____ _____

Print Name Birth date

Donald G. Rebhun, D.M.D.

Oral and Maxillofacial Surgery

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this agreement

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 situation prevented us from obtaining acknowledgement

Other (Please Specify)