

**WESTWOOD DENTAL
OFFICE, FINANCIAL AND INSURANCE POLICIES**

The dental providers and staff of Westwood Dental strive to offer comprehensive, quality care to all of our patients. We feel that it is appropriate to inform our patients in advance of the office, financial and insurance policies required at Westwood Dental that may ultimately affect their care. Please read the following policies carefully and initial after each. Please sign and date your understanding at the end of this form. If you are a patient under the age of 18, your responsible party must also read and sign this form.

Cash Accounts

I am responsible, at the time of service, for all expenses incurred during my office visit. Westwood Dental accepts cash, checks, money orders, MasterCard, Visa, Discover and American Express credit cards. We also accept CareCredit as a payment plan. Initials_____

Insurance Co-pays

My co-pay is due at the time of my appointment. If I do not have my co-pay I will be asked to reschedule my appointment. Westwood Dental accepts cash, checks, money orders, MasterCard, Visa, American Express and Discover Credit Cards. We also accept CareCredit. Initials_____

Non-Covered Services

Non-Covered services will need to be paid at the time of service. Possible examples of non-covered services include teeth whitening, nitrous oxide, OHI instructions, irrigation or any procedure not covered under your particular insurance contract. I understand that my insurance company may not cover composite (white) fillings. If my insurance company only covers Mercury fillings I understand that I am responsible for the difference in cost. I understand that I am responsible for checking my benefits with my insurance carrier before my appointment time. Initials_____

Returned Check Fees

I understand that if Westwood Dental receives a returned check written by me or on my behalf, I will be charged a returned check fee of \$30.00 and will be required to pay cash or use a credit card for any future payments for a period of one year. Failure to repay the returned check and the returned check fee will result in collection proceedings and dismissal as a patient from Westwood Dental. Initials_____

Account Interest

I understand that my account balance must be paid within 90 days of incurring an account balance. Account interest will be calculated each month on the amount of the unpaid balance (referred to as Previous Balance) after deducting payments or adjustments and before adding new services. After 90 days I will be charged at a rate of 18% per annum and charged on a monthly basis thereafter until the balance is paid in full. Initials_____

Collection Process

Any balances determined as patient responsibility that remain unpaid after 90 days will be subject to an in house review. If at that time satisfactory payment arrangements have not been established, I understand that I will receive a letter from Westwood Dental notifying that I have until the end of the current month to pay my balance in full or my account will be forwarded to an outside collection agency and I will be

subject to an additional processing fee of \$15.00. I further understand that I will not be allowed to schedule any further appointments with Westwood Dental, receive any medication refills or seek any medical advice of any kind from Westwood Dental until this collection balance is paid in full. In the event my account is sent to an outside collection agency, I understand that I will be obligated to pay for any reasonable attorney fees and court costs should the collection proceedings advance to litigation. Initials_____

Missed Appointments

I understand that Westwood Dental may, but is not required to, call my home to confirm my upcoming appointment date and time. I understand that this is a courtesy and that I am ultimately responsible to keep my office appointment. I understand that Westwood Dental may charge a \$50 missed appointment fee for appointments missed and not changed or cancelled within 24 hours prior to my scheduled appointment. Initials_____

After Hours Phone Calls

Dental providers should only be called or paged after normal business hours for serious dental concerns. Westwood Dentals normal business hours are 7:00 AM to 5:00 PM Monday through Thursday and 9:00 AM to 1:00 PM on Fridays. We encourage our patients to call during normal business hours. Emergency calls may be directed to our pager at 913-613-0345. This number is on our answering service. Initials_____

Dental Records Release

Westwood Dental will only release dental records when a valid HIPPA compliant authorization or a court-ordered subpoena is received. Initials_____

Discharge of a Patient

I understand that Westwood Dental has the right to discharge any patient from this practice at any time for various reasons, including, but not limited to failure to abide by Westwood Dental financial policies, noncompliance of recommended treatment, drug-seeking activity, and any abuse of Westwood Dental providers and staff. If this occurs, I understand that my dental records will be released to a dentist of my choice only after appropriately signed documentation is received by Westwood Dental. I further understand that once discharged from Westwood Dental, I will not be allowed to return as a patient of Westwood Dental in the future. Initials_____

Final Costs of Service

I understand that I may inquire about costs of services. I also understand that Westwood Dental representatives can only estimate potential costs and cannot guarantee my final costs until all procedures have been performed. Initials_____

Westwood Dental Insurance Policy

Westwood Dental participates with many insurance carriers and it is my responsibility to choose a dental provider that participates with my insurance plan. It is my responsibility to contact my insurance carrier for a list of participating providers. I am also responsible for informing Westwood Dental if my insurance changes. **Please note: Your insurance policy is a contract between you and the insurance company and we have no leverage to obtain payment from your insurance company.** I am ultimately responsible for all charges incurred at Westwood Dental. It is my responsibility to know the benefits and provisions of

my insurance policy. If I have any questions or concerns regarding the benefits of my policy, I should contact my insurance company directly.

I hereby authorize Westwood Dental (Shelly M. Galvin, DDS, PA) to submit a claim and to furnish complete information to my insurance carrier for all services rendered to me by my dental provider and authorize and direct my insurance carrier to issue payment on my behalf to Westwood Dental (Shelly M. Galvin, DDS, PA.). Initials_____

Authorization of Treatment

While I am here, I permit the dental providers, Westwood Dental staff and all other persons caring for me to treat me in ways they judge beneficial to me. I understand the dental provider will explain to me the recommended treatment and risks if any. Initials_____

I HAVE READ AND UNDERSTAND THE OFFICE, INSURANCE AND FINANCIAL POLICIES OF WESTWOOD DENTAL.

Please print patient name_____

Patient Signature_____Date_____

If patient is less than 18 years of age:

Please print responsible party name_____

Responsible party signature_____Date_____

Relationship to patient_____

