# BRENDEN SCOTT, D.M.D. - FINANCIAL POLICY

**Payment is expected at the time of service. If you have a dental insurance plan your co-payment and deductible are due at the time of service. As a service to our patients, we will bill your insurance company.**

## ACCEPTED FORMS OF PAYMENT:

1. Cash, check, debit or credit cards (Visa, MasterCard, American Express and Discover).
2. Most dental insurance plans.
3. Third party financing through Care Credit. (on approved credit).

## DENTAL INSURANCE:

- **PRIMARY INSURANCE:** We require that all insurance co-pays and estimated patient balance, minus estimated insurance assistance, be paid at the time of service. As a service, we will bill your services rendered. To do so we must receive an updated copy of your insurance card at your appointment. If necessary, we will submit a pre-treatment "estimate of benefits" request to your insurance company before we schedule your treatment. This allows us to obtain an *estimate* of your dental benefits and the *estimated* amount your dental plan expects you to be responsible for; however we ***do not guarantee*** dental insurance estimates. **While we help you to maximize your allowable insurance benefits, the insurance contract is between you (the insured) and your insurance company, and does not replace your responsibility for your account with us.** Any balance not paid by the insurance company remains your responsibility, including the balance exceeding usual and customary rates (UCR).
- **SECONDARY INSURANCE:** Having more than one insurance **DOES NOT** necessarily mean your dental services are covered 100%. As a service we will gladly bill your secondary insurance company. **Any balance not paid by your secondary insurance company remains your responsibility.**

## 5% COURTESY ADJUSTMENT:

This is our way of saying thank-you for maintaining your account in good-standing by paying your bill in full with minimal administrative overhead on our part. Cash, check, or credit card payments are eligible to receive the 5% courtesy adjustment. A 5% courtesy adjustment will not be given if we are managing your insurance, mailing statements, or otherwise administering your account. Your previous account balance must be zero to receive the 5% courtesy adjustment.

Returned checks are subject to a fee of $25.00 (per check). In the event that your account is not paid in full, you may be referred to a collection agency. You will be responsible for all the fees incurred for collection of your bill.

Your appointment has been reserved exclusively for you. Any change in your appointment affects many patients.
**We respectfully ask that you provide 48 business hours notice, if you need to change an appointment.**

We are committed to delivering the best quality dental treatment for our patients' and we charge what is usual and customary for our area.

**I hereby authorize release of any information to my insurance carrier regarding my treatment. I also hereby authorize any insurance benefits otherwise payable to me to be paid directly to Brenden C. Scott, DMD for services provided. By signing below, I acknowledge that I have read, understand and agree to the terms of this Financial Policy. This agreement stays in force until changed in writing.**

(Name of patient or responsible party – PLEASE PRINT) (Signature) (Date)

# Permission to Disclose Health Information

## BRENDEN SCOTT, D.M.D.

Name of Practice

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, **but only if you agree that we may do so.** Please list the individuals below who have your permission to share your health information:

| Name | Relationship to Patient | Conditions of Access |
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# BRENDEN SCOTT, DMD

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this office's Notice of Private 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)

_____

_____

_____

You have the right to receive a copy of the Privacy Policy Act at your request.

# BRENDEN C. SCOTT DDS

# NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**
**THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 01/01/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.