Agreement to Receive Electronic Communication

Cosmetic Dentistry Implant Dentistry Family Dentistry Orthodontics Endodontics

Patient Name:_____ Date of Birth_____

(Initial below)

I_____DO AGREE

I_____DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

_____Text Messaging

_____Email

I would like to receive:

_____Appointment Reminder/Recall Visits

_____Information Regarding Insurance/Billing

_____Requests for Patient Satisfaction Online Reviews

I can withdraw my consent to electronic communications at any time by calling:

Hill View Dental

2535 S. Lewis Way Ste 109

Lakewood, CO 80227

303-985-9850

Patient Signature:_____Date_____

FINANCIAL POLICY

Thank you for choosing Hill View Dental for your dental health care. We are committed to providing you with the best possible dental care and are pleased to discuss any and all of our professional fees with you at any time. Your clear understanding of our Financial Agreement is very important to our professional dental relationship. If you have any questions or concerns, please ask one of our qualified team members.

It is important to remember that your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending upon what your employer has agreed to with the insurer. Please keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to assist in cost of dental care.

As a courtesy to our patients, we are happy to file claims on your behalf. To do this, you must provide us accurate and up-to-date insurance information.

- Your estimated out-of-pocket expense is required at the time of service unless prior arrangements have been made.
- We accept Cash, Check, Debit Cards, Visa, Mastercard, Discover, American Express and Care Credit.
- Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement.
- Our office is committed to helping you maximize your insurance benefits. Because insurance policies vary, we can only estimate your coverage in good faith, but cannot guarantee coverage due to the complexities of insurance contracts.
- We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed.
- We will attempt to help you receive full insurance benefits; however, you are personally responsible for your account, and we encourage you to contact your insurance company if they have not paid within 30 days.
- Your treatment plan will include a breakdown of all applicable fees, and we will inform you of all cost before treatment is administered. If special arrangements are needed, please talk to our financial manager prior to receiving service.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment to the account, in accordance with the policies outlined herein.

Broken Appointments / Short Notice Cancellations: Your scheduled appointment time has been reserved specifically for you. If you are unable to keep an appointment, please notify us (even after hours) of at least 48 hours in advance. Failure to notify us less than 24 hours before your appointment may result in a minimum broken appointment charge of $100.

Returned Checks: For checks returned to us, as unpaid by your bank, you will be charged a $35 fee.

Past Due Accounts: Overdue accounts will be referred to a collection agency if more than 90 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the Financial Policies and agree to all terms and conditions as stated above. I certify that the information that I have provided is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform Hill View Dental of any changes associated with my insurance status. I agree to make an in-full prompt payment to Hill View Dental when billed for any and all charges not covered or paid by insurance. I hereby assign and direct to pay any and all benefits for dental services under this claim to Hill View Dental.

I authorize the release of any dental information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

Hill View Dental has my authorization to charge my credit card for any current or past due personal balance upon receiving my verbal or written permission

Patient/Guardian Signature:_____ Date _____