BLUE SKY FAMILY DENTAL
Dr. Amy Li, DMD

Patient Name _____
Date of Birth _____

Office and Financial Policy

Welcome to Blue Sky Family Dental. We are proud to have you as our patient and look forward to delivering you the finest and most comprehensive dental care. We know that providing complete comprehensive dental services includes discussing all treatment and financial information. This will allow you to fully understand your dental treatment, what to anticipate in fees and allow you time to make the necessary financial arrangements. We want a transparent and clear understanding so no treatment will be delayed in providing the utmost care you need to obtain the smile you want!

Payment Options

- **For all patients, payment is due at the time services are rendered.**
- For patients with insurance, we will collect any deductible and/or estimated co-payment at the time of service.
- For your convenience we accept cash, Visa, MasterCard, Discover, American Express, money orders and registered checks; we also offer financing through Care Credit.
- If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be paid by you.
- Treatment appointments made that exceed $500.00 will require a 10% down payment to hold the appointed time.
- Emergency clients, new to our practice, should expect to make a payment at the time of service. However, the insurance claim will be submitted as a courtesy to you and allow the insurance company to reimburse you for that visit. Once established as an active patient, we will be happy to discuss payment options.

Insurance

- As a courtesy to you, we will file a claim for a payment with your insurance company.
- Insurance benefits are determined by your employer, not your dentist. Your insurance policy is a contract between you and your insurance company. Your insurance coverage and benefits are your responsibility.
- **Any deductible or estimated co-payment amount will be due at the time of treatment**.
- Our office makes no guarantee of the actual payment by your insurance company, which may differ from the original estimate.
- Insurance is not a guarantee of payment; it often does not cover all the costs involved in treatment. You will be expected to pay for services rendered if this office is unable to verify your insurance information before treatment.
- Not all services we provide are covered benefits by insurance. Fees for non-covered services are due at or prior to the time of service.

We want you to feel comfortable and confident in all aspects of our practice. Remember we do not treat according to your insurance we treat you as an individual and care about your dental health, and are dedicated to providing the best treatment available to our patients.

Missed Appointments

- Appointments are reserved exclusively for you. If you need to reschedule your appointment to another date or time, we will make all efforts to accommodate.
- If an appointment is not canceled at least 24 hours in advance, or if you fail to keep your appointment, you will be charged **a fifty ($50)** fee.
- For appointment 2 hours or more in length, a fee of **one hundred and fifty-dollar ($150)** will be charged for all missed and short notice cancellations. This fee will not be covered by your insurance company
- Our office reserves the right to limit future appointments if short notice cancellations occur more than twice.

Regarding Minors in the office

Minors (under 18 years old) **MUST ALWAYS** be accompanied by an adult; the adult accompanying a minor will be responsible for payment of services on their appointment. If parent is giving authorization for a Caregiver, the permission form needs to be completed prior to their visit.

Your Right - Copy and/or Transfer of your Records

You have the right to inspect and copy your health information and related records, by filling out our release authorization form, records will be sent within 10 days of the receipt of your written request and receipt of the administrative fee. For providing an electronic or paper copy of your health information, we will charge you an administrative fee in responding to your request.

Office Surveillance

Please be advised that all activities within the office are under continuous audio and visual surveillance and recording. We adhere to all HIPAA guidelines as related to these recordings and all office records.

CONSENT

I have read and understand all the above Office and Financial Policy. Any questions and concerns were answered fully to my satisfaction. The undersigned hereby authorizes the Doctor at Blue Sky Family Dental, PLLC to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company. Furthermore, I authorize the release of any information relating to my insurance claims and the assignment of any and all dental benefits paid directly to Blue Sky Family Dental, PLLC. I understand that I am responsible for all costs of dental treatment and any additional costs incurred in collecting this account, including interest, court cost and attorney fees, which may be added to my balance. I agree to the above policies and charges.

Printed Name	Signature	Date

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