ALTOONA SMILES PC
Family and Cosmetic Dentistry
In with a grin. Out with a smile!

950 28th Ave SW • Suite 2 • Altoona, IA 50009 • www.altoonasmiles.com • Phone: (515) 967-3046

PATIENT RIGHTS & RESPONSIBILITIES

YOUR RIGHTS AS A PATIENT

You have a right to:

1. Choose your own Doctor and schedule an appointment in a timely manner.
2. Know the education and training of your Dentist and the dental care team.
3. Adequate time to ask questions and receive answers regarding your dental condition and treatment plan for your care.
4. Know what the Doctor feels is the optimal treatment plan as well as the right to ask for alternative treatment options.
5. An explanation of the purpose, probable (short and long term) results, alternative and risks involved before consenting to a proposed treatment plan.
6. Be informed of continuing health care needs.
7. Know in advance the ***estimated*** cost of treatment.
8. Receive considerate, respectful and confidential treatment by your dentist and dental team.
9. Expect dental team members to use appropriate infection and sterilization controls.
10. Inquire about the availability of processes to mediate disputes about your treatment.

FINANCIAL POLICY

We accept assignment of insurance benefits. Meaning, in order for our office to submit your insurance claim as a courtesy to you, you must supply us with a valid dental card or an original claim form prior to services being rendered. Our team will give you the best ***estimate*** possible for treatment based off of the information supplied from your insurance company. It is ***your*** responsibility to request a pre-treatment estimate from your insurance company prior to services being rendered for their allowable amounts. However, your insurance company still reserves the right to deny a claim that has been pre-authorized. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a policy between you, your employer, and your insurance company. Altoona Smiles, PC is not a party to that contract. **OUR DOCTORS WILL DIAGNOSE TREATMENT BASED OFF OF YOUR DENTAL HEALTH, NOT YOUR INSURANCE BENEFITS.** We are committed to providing the best treatment possible for our patients and we charge our usual and customary rate. You are responsible for payment regardless of any insurance company's arbitrary determination of a usual and customary rate.

ALL SATURDAY APPOINTMENTS REQUIRE YOUR ESTIMATED PATIENT PORTION OR A $36 DEPOSIT, WHICHEVER IS GREATER TO RESERVE AN APPOINTMENT TIME.

Adult patients and those accompanying minors are responsible for all deductibles, patient co-pays and patient portions. Payment is due ***in full at the time of service***. **We reserve the right to take action on any account balances over 60 days past due.** Forms of payment we gladly accept include:

- Cash
- Personal Check
- Credit Card (Visa, MasterCard, Discover, AMEX)
- Care Credit – 0% deferred interest for qualifying treatment plans, upon credit approval
- Layaway plans with pre-arrangements

ANY REFUNDS WILL BE ISSUED IN THE ORIGINAL FORM OF PAYMENT ONLY & AFTER A FINAL EOB/PAYMENT HAS BEEN RECEIVED FROM YOUR INSURANCE COMPANY, IF APPLICABLE.

CANCELLATION/RESCHEDULING POLICY

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient schedule. We understand emergencies and unexpected events in life can occur. However, our cost of providing care increases greatly when patients fail to keep scheduled appointments or cancel at the last minute. We require a 48-hour notice for any scheduling concerns***. Late notice cancellations will require a deposit in the amount of the patient co-pay or $36, whichever is greater, to reschedule.***

PATIENT CONSENT

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your protected health information. You must understand that this information can and will be used to conduct, plan and direct treatment with multiple healthcare providers, obtain 3rd party payers and conduct normal healthcare operations. A copy of our *Notice of Privacy Policies* is available for all patients. We have the right to change it from time to time and you may contact us at any time to obtain a current copy. You may request in writing to restrict how our private information is used or disclosed to carry out treatment, payment or healthcare operations. We are not required to agree or abide by your requested restrictions.

MINOR CONSENT

Altoona Smiles asks a parent/legal guardian to be present for all minor children's dental visits. I understand by choosing not to attend my minor child's dental visit I am hereby consenting to my child receiving preventive care as prescribed by the treating dentist (exam, x-rays, cleaning, fluoride) and accept full financial responsibility for services provided, regardless of any insurance coverage. If additional treatments, procedures, or prescriptions are recommended or required beyond those listed, I will receive a written estimate in advance of treatment. I am responsible for the actions of my unattended minor child and may be held accountable to those actions.

CONSENT TO BEGIN TREATMENT

I consent to the release of any information, including x-rays, as requested by my insurance company or at my request to any healthcare provider. I have read and understand the financial and cancelation policy as written.

Patient name: _____Date:_____

Signature: _____Relationship:_____