KOHLMEIER DENTAL LLC

1104 E 12th Ave • Emporia, KS 66801 • 620-342-9555 • emporiasmiles.com

Thank you for choosing our practice to provide your dental care. The following is a statement of our financial policy and protection of privacy and confidentiality of patient information (see HIPAA below). **We ask that you please read this statement completely before signing it.**

Payment in full is expected at the time of service. If you have dental insurance or other dental benefits, you will be expected to pay any deductible or co-insurance as outlined in your plan. Any overpayment/credit created by payment from your insurance company in addition your personal payment will be refunded to you in a timely manner. A courtesy discount of 5% will be offered for patients without insurance whose accounts are paid in full on the day of service. This discount does not apply to patients financing treatment through CareCredit, or any other alternative means of financing. We will apply a finance charge of 18% per year on all balances over sixty days. Prior arrangements are required for anyone needing to make partial payments on treatment.

As a courtesy to you, our office will file your insurance claims on your behalf. Please provide us with a current insurance card for our files. **Your insurance policy is a contract between you and your insurance company. It is your responsibility to know what your insurance policy covers and to contact your insurance company regarding any discrepancies in payment or treatment eligibility.** Please be aware that some, and perhaps all of the services provided, may not be covered by dental insurance or other benefit programs. You will be responsible for payment for all non-covered services.

HIPAA (Health Insurance Portability and Accountability Act) has mandated that patients be informed of medical office billing policies and of patient information protection of privacy and confidentiality. No information regarding your health care or status of account will be released unless your written authorization has been obtained. This office reserves the right to release account balance and billing information to a lawyer or credit and collections bureau, as needed should your account become delinquent.

I hereby consent to the release of any information to other dental/healthcare providers as needed for specialized treatment.

I HAVE READ AND UNDERSTAND THIS FINANCIAL POLICY.

_____ Date_____

Signature of patient or responsible party