PATIENT ACKNOWLEDGMENTS AND AUTHORIZATIONS

Our mission is to be helpful, including providing clarity concerning treatment planning, costs, and utilization of dental benefits. We'd like to explain your financial and scheduling responsibilities toward our goal of minimizing your costs and minimizing surprises.

Payment: Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: cash, personal check, credit card, and CareCredit.

Dental Benefit Plans: Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage.

- **If we are a contracted provider with your plan,** you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.
- **If we are not a contracted provider with your dental benefit plan,** it is your responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

Scheduling of Appointments: We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide. To maintain the utmost service and care, we require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $75 or a deposit to reserve an appointment time again may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is exceedingly late arriving to our practice.

PATIENT AUTHORIZATIONS

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that I may need and have consented to during diagnosis and treatment. ________ (Initial)

I have read the above and agree to the financial and scheduling terms. ________ (Initial)

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to Dr. Matthew Ryan otherwise payable to me. ☐ YES ☐ NO ________ (initial)

PATIENT COMMUNICATION

Voice Messages: I understand brief messages from the dental practice may be left on my home answering machine or with anyone who answers the telephone at my home unless I have provided the practice with alternate instructions for communication. ________ (Initial)

Email: Except for appointment reminders, we use secure methods to electronically communicate with our patients. **Unencrypted email is not a secure form of communication.** There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive unsecured email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify your email address *(please initial one of the four options below)*.

______ I prefer to receive information via the practice's secure communication methods.

______ I consent and accept the risk in receiving information via unencrypted email. I understand I can withdraw my consent at any time.

______ I consent to receiving appointment reminders via unencrypted email. I understand the minimum necessary information is used in these reminders. I understand I can withdraw my consent at any time.

______ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

MOBILE PHONE

______ I consent to the dental practice using my mobile phone number to *(choose one or both)* ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time.

PATIENT ACKNOWLEDGMENTS

I hereby acknowledge that a copy of this practice's **Statement of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. _______ (Initial)

I hereby acknowledge that a copy of this practice's **Dental Materials Fact Sheet** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. _______ (Initial)