Trisha T Goldsby DDS, PS
388 SW 13th St / PO Box 120
Chehalis, WA 98532

OFFICE POLICY

Our office attempts to remind you of your appointments, but it is strictly a courtesy call. If appointments are missed without cancellation or without 24 hours notice in advance, you may be charged a $45.00 fee that will not be billed to insurance. Two occurrences risk the chance of being discharged from the practice.

FINANCIAL POLICY

It is our policy to receive payment in full for dental treatment at the time of service. If you have dental insurance, we ask that you make yourself knowledgeable about it and make sure that your benefits officer tells you exactly what is covered and what is not.

DENTAL INSURANCE

As a courtesy to our patients, we will file the necessary forms to see that you receive the full benefits of your coverage. **We do our best to estimate patients' portion, which is due at the time of service**; however, insurance companies do not always pay what is expected. Due to the rising costs of sending statements out each month, **there will be an additional $10.00 charge for each time that your portion is not paid at that visit**. For crowns, we will expect half the fee on the prep date and the remaining balance on the seat date. If for some reason your insurance company has not paid their portion within 60 days from the date of service, you are responsible for the balance at that time. In addition, 1% will automatically be added monthly on any remaining balance over 90 days until account is paid in full. Please note our agreement is with you, NOT your insurance company. You are responsible for the cost of your treatment and any insurance reimbursement problems. If your insurance company refuses to pay or pays less than you think it should you must remember that dental insurance is designed to offset the costs of your dental treatment. It is unusual for all charges to be paid in full by an insurance company. **It is your responsibility to know your insurance benefits and if your appointment will be covered!**

PAYMENT OPTIONS

Cash or Check: We offer our uninsured patients a 10% cash courtesy for payment in full at time of services. A $30.00 fee will be charged for all returned checks.
Credit Cards: We gladly accept payment by all major credit cards.

Should the account be referred for collection the undersigned shall pay reasonable attorney fees and collection expenses. In the event of court action, venue and jurisdiction shall be Lewis County in the State of Washington.

I have read and understand the above financial policy. Regardless of insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependents. I authorize Dr. Trisha Goldsby DDS to furnish information to insurance carriers concerning myself and/or my dependent's treatment. I hereby assign to the dentist all payment for dental services rendered.

Patient or Guardian Signature_____ **Date**_____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Trisha T. Goldsby D.D.S., P.S.
388 SW 13th St. / P.O. Box 120
Chehalis, WA 98532
(360) 748-6624

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ **Date:** _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

ADDITIONAL DISCLOSURE AUTHORITY

May we discuss your treatment and billing with:

- **Entire Family:** **y** **n**
- **Spouse only:** **y** **n**
- **Other:** _____ **y** **n**

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other