All Valley Smiles, Inc.
Cosmetic & Family Dentistry
21 Central Plaza • Ilion, NY 13357
T: 315-895-5555 • F: 315-895-5630
www.AllValleySmiles.com • allvalleysmiles@yahoo.com

HIPAA CONSENT

Patient Name

I give this practice/clinic my consent to use or disclose my or my child's protected health information to carry out my treatment, to confirm appointments, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also, understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Print your name: _____
Patient, parent, or legal guardian

Your Signature: _____
Patient, parent, or legal guardian

Date:_____

If signed by a patient representative, state the relationship to the patient _____.

All Valley Smiles, Inc.

Cosmetic & Family Dentistry

FINANCIAL POLICY

All Valley Smiles, Inc, the Dentists, providers and staff are dedicated to providing the best possible care for you. We value the trust and responsibility you place in us to provide you with the most quality care. Our fees are based on the quality of the products and materials we use and our experience in performing your scheduled treatment.

Patient Responsibility: We ask for payment at time of service. For patients who have insurance, the entire estimated patient portion is due at the time of service. You must present your insurance card(s) at each visit. We will perform an initial insurance verification and do our best to provide you an estimate of your copay prior to your appointment. For your convenience, we do accept cash, personal or bank checks, money orders, Visa, MasterCard, and Discover. * All returned checks will be charged a **$25.00 processing fee**.* We also offer Care Credit with flexible financing options like 6 to 12 Months Interest-Free Payment Plans or Low-Interest Extended Payment Plans.

It is your responsibility to know your insurance benefits and to ensure that we participate with your insurance carrier. Our office cannot always tell you in advance whether or not your charges will be covered by your insurance Plan. Each insurance company has multiple plans that can vary with employer group contracts. Since your coverage is a contract between you and your insurance carrier, we expect you to be aware of services that may not be covered under your contract. As a courtesy, we will gladly process your insurance claims and estimate the amounts not covered by your insurance. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage and any balance left after receipt of insurance payment is due immediately.

Collections: All accounts with a balance over 30 days will be assessed a **1.50%** rate charge or **$5.00** (whichever is higher) per month on the unpaid monthly patient balance. Patients who do not make reasonable progress toward resolving outstanding debt to the practice may be turned over to our collection agency. There will be a **$35.00 fee** charged to your account for collection agency processing. Also, you will be responsible for any attorney fees and other legal costs in addition to the outstanding balance.

APPOINTMENT POLICY

Office Policy for Scheduled Appointments: We ask that you appreciate the fact that if you miss or cancel an appointment at the last moment, we will be unable to fill your time slot with another patient who needs an appointment. (You would expect the same consideration when you have an urgent problem and need us to see you.) Therefore, if you need to cancel or re-schedule your appointment, we ask you to give us 48 hours notice. If you fail to give us such notice, we reserve the right to charge you a **$50.00 no-show fee** (which is not covered by insurance). Excessive abuse of the scheduled appointments (no shows, chronic lateness, etc.) may result in discharge from the practice.

I have read and understand the practice's Financial policy and Office policy for Scheduled Appointments and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice as needed.

_____

Name of Patient

_____ _____

Signature of Patient / Responsible Party Date