W. Blake Bybee DDS
5833 W Hidden Springs Dr
Boise, ID 83714
(208)229-4900

Thank you for choosing our practice as your dental health care provider. Our practice is dedicated to quality care and exceptional service. We need your assistance and understanding of our appointment, insurance and financial policies. Thank you for your cooperation in this matter.

PLEASE READ AND INITIAL EACH LINE THEN SIGN AND DATE AT THE END

APPOINTMENTS

We respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all our patients. In return, we ask that patients make every effort not to change their reserved appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice. We require a minimum of **24 hour notice** for any appointment changes so we may accommodate another patient**. If less than 24 hours is given, you will be charged a $40/per hour broken appointment fee.** Appointments are confirmed by mail/phone. If we are unable to reach you, we trust that you will keep your reserved appointment. _____

INSURANCE

If you have dental insurance, as a courtesy to you, we will file your claims with your insurance company. We will try to research and answer any questions you may have about your insurance; however, we must emphasize that as a dental care provider, our relationship is with you-not your insurance company. It is your responsibility to know your insurance policy and be familiar with your coverage. If you have any questions regarding coverage or payment of any claim, that we cannot answer, contact your insurance company immediately. **If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible from the patient.** _____

FINANCIAL

Payments are due at the time treatment is rendered. That includes all estimated deductibles and co-payments. We accept cash, checks, Visa, MasterCard, discover and American Express. We also offer Care Credit, a dedicated credit card for health services with convenient monthly payments (O.A.C.). You may contact Care Credit at www.carecredit.com or we can help assist you with the application in the office. **If you have a flex/health savings reimbursement program** through your employer, we will be happy to provide you, upon payment in full for your account, with whatever documents are needed for you to obtain direct reimbursement. **Accounts with a balance over 90 days are considered delinquent and may be turned over to a third party collections service**. _____

PAST DUE BALANCES

A past due balance is any amount owing from a prior visit, where insurance is not pending or an insurance payment has not been received by us within 90 days. If you have a past due balance and wish to receive service, you will be required to pay the past due balance and the new charges at the time of service**. Any balance older than 90 days is subject to a billing charge of $5.00 per month or finance charges of 18.0% A.P.R.** _____

I understand and agree that regardless of my insurance, I am ultimately responsible for the balance on my account for any professional services received. I have read the above information and agree to the above stated policy, and have received a copy of said policy.

_____

Signature of Patient or Responsible Party Date

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HIPAA

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day to day healthcare operation of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this ____day of _____, 2017

Print Patient Name:_____

Signature:_____