JORDAN J TILDEN DDS, PC & ASSOCIATES

OFFICE & FINANCIAL POLICY

Thank you for choosing our office for your dental care. It is our mission to provide you with the highest quality of patient care. Please review our financial policy and sign below.

The patient is responsible for payment of their estimated portion of payment at the time of service, unless written financial arrangements have been made.

We calculate your portion based on the most up-to-date information we have by verifying your benefits with your insurance provider, but it is only an estimate. Any amount not paid by insurance is the patient's responsibility and we are not responsible for denials of service by your insurance provider. Insurance benefits are not a guarantee of payment and the patient is responsible for the balance. We encourage you to discuss any concerns or questions you may have regarding your specific plan with your insurance company, as you are their client.

We accept all major credit cards, personal checks, and cash. To make your dental care affordable, we also offer interest-free payment plans for 12 months through CareCredit financing.

We will do our best to contact you prior to your appointment, however, this is a courtesy reminder, and you are still responsible for keeping your appointment. Your appointment is just for you. **A fee of $100 for the doctor/$75 for the hygiene visits will be charged for appointments that are missed or cancelled without 48-hour notice.**

We send out regular statements for any balance that may accrue on your account. An interest charge of 5% monthly will be applied to any account with a balance showing no payment activity after 90 days of issuance of the first statement. Though we try to resolve all financial issues as cordially as possible, continued lack of payment will result in the account being sent to a collection agency for resolution. Please speak with our staff for an explanation of financial options available.

I understand and agree to the office policy of Jordan J. Tilden DDS, PC & Associates

Dated: / /

Patient (or Guardian) Signature

Printed Name

FINANCIAL POLICY

Credit Card Policy: Initials _____
Our office requires a valid credit card or direct bank debit account information prior to services being rendered. Your credit card/bank account will not be charged until 90 days after the services provided have been processed by your dental insurance carrier and the balance deemed your responsibility. You will be notified by letter and/or phone of any outstanding balances prior to our office charging your card or account at which time we will inform you of all of your payment options.

Name of Card Holder: _____

Name of Patient: _____

Card #_____ Exp: _____ CVV: _____

Circle One: Visa MasterCard Discover American Express

Authorized Signature: _____

Cancelled/Failed Appointments: Initials _____
If you are unable to keep your scheduled appointment, please call our office within 48 hours to reschedule your appointment. This will provide time to use your appointment time for another patient.

No Insurance Coverage: Initials _____
Payment will be due at the time of service. If you are unable to pay your balance in full, you will need to make a prior arrangement with our Business Manager or Financial Coordinator.

Returned Checks: Initials _____
A $39.00 charge will be added to your account for any check returned by your bank for any reason.

Requesting Dental Records & X-rays: Initials _____
We will provide you a copy of your dental records upon request. You will need to sign a letter of release to send a copy to you or your new dental office via email or mail. Please allow 24 hours to receive the documents after request.

CONSENT FOR DENTAL TREATMENT

I hereby authorize Dr. Jordan Tilden and/or Dr. Zachary Tilden (hereafter called "Doctor") and designated staff auxiliaries to perform the dental treatment once the diagnosis and treatment plan is explained to me.

_____

PATIENT NAME

TREATMENT PLAN MAY INCLUDE:

- Bonded restorations
- Crowns, bridges, veneers
- Removable partial or full dentures
- Extractions
- Minor gingival surgery as necessary for crown and bridgework
- Scaling and root planing
- Prophylaxis (healthy teeth and gums type cleaning) and x-rays
- Periodontal maintenance (gum disease management type cleaning)
- Orthodontic tooth alignment

NON-TREATMENT RISKS:

I understand that if no treatment is rendered, the risk to my dental health may include, but is not limited to the following: cavities, teeth breakage, premature loss of teeth, gum recession, halitosis, loosening of teeth, abscesses, teeth drifting or flaring, deepening of pockets and loss of supporting bone.

RISKS OF TREATMENT:

I understand that removing decay from teeth may in some cases result in temporary tooth sensitivity. I also understand that although unlikely, a tooth may become very sensitive and require root canal treatment at some later date.

The Doctor will use the best materials and his best judgement in order to get the best results, but I understand that crowns, bridges, implants, and other restorations are medical devices and are subject to wear and tear in the mouth.

I authorize the Doctor to do whatever he deems advisable to take care of any unforeseen conditions that may arise during the procedures. By signing below, I give my consent for the proposed treatment.

I also understand that long-term success requires my continuous cooperation of daily plaque control (home brushing/flossing) and periodic maintenance visits to the dental office. **Initials** _____

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist(s) and to all diagnostic methods deemed appropriate by the dentist(s) which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist(s) and designated auxiliary staff to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist(s) may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this. I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company. For any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist, I acknowledge that it is my responsibility to pay all quoted costs. **Initials _____**

ACCOUNTS BEING REFERRED TO COLLECTIONS:

All returned checks will be subject to a $39.00 returned check fee. Any account balances that remain unpaid for 180 days from the date of service shall accrue interest at the rate of five percent (5%) per month and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for all reasonable collection costs. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address, email address, or phone number (whether a cell phone or landline) that I provide to the dental office and/or by facsimile that I provide to the dental office or any agent of the dental office. **Initials _____**

Printed Name: _____ Dated: _____

Signed: _____

Guardian/Responsible Party, if minor: _____

Signed: _____

HIPAA OMNIBUS RULE
"HIPAA PRIVACY NOTICE"
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In this case we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A "PHI" (PROTECTED HEALTH INFORMATION) DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

_____ _____

Printed name of patient Signature of Patient/Guardian

_____ _____

Legal Representative/Guardian Relationship of Legal Representative/Guardian

Date: _____

In signing this HIPAA Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office does not receive third party remuneration from these affiliated companies. We under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Brindell Tilden

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Signature of Privacy Officer