FINANCIAL POLICY

PROMISE TO PAY and COLLECTION COSTS

Payments are due on date of service, prior to being seated, and the only forms of payment that are accepted are:

Cash, debit/credit cards, HSA/FSA cards, and Care Credit.

As a condition of your treatment by this office financial arrangements must be made in advance. If you have insurance, the amount owed for services is ESTIMATED based on the amount anticipated to be paid by your insurance company. We will assist you with your insurance claim; however, insurance is a contact between the policy holder and insurance company. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies and will credit any collections from insurance to the patient's accounts.

IN THE EVENT YOUR INSURANCE COMPANY IS SLOW TO PAY OR DISALLOWS A CLAIM, PAYMENT OF YOUR DENTAL SERVICES IS YOUR FULL RESPONSIBILITY.

This dental office cannot render services on the assumption that the resulting charged will be covered by insurance. We will provide to you a statement of your balance which is payable UPON RECEIPT. We may indicate on your statement that your balance is pending insurance and thus not yet payable by you. If you have insurance coverage, we may choose to send you a statement until we know or receive the amount reimbursable by your insurance company.

If we do not receive payment under the terms of this financial policy and we refer your account to a collection agency or an attorney for collection, we may charge your account our collection costs, including court costs and reasonable attorneys' fees, to the extend not prohibited by applicable law. We may report late or missed payments on your account to credit reporting agencies. Please notify us if you believe we are reporting inaccurate information.

Yes, I agree to the above terms and conditions.
Signature of guarantor of payment/responsible party: ________________________________ Date: ___________

MISSED APPOINTMENTS, BROKEN APPOINTMENTS and RESERVATION FEES

The Smile Institute of Family Dentistry requires 24 hours notice to cancel or reschedule any appointment. We can be notified via phone, voicemail, email, text message, and in-person.

An appointment will be considered **"broken"** if a patient does not give 24 hours notice to reschedule an appointment, the patient does not show up to an appointment, or the patient shows up to the appointment and cannot pay for services. If the patient cannot pay, we will not be able to see the patient because payments are due prior to being seated (unless otherwise noted).

If you cancel or miss an appointment without 24 hours notice, we reserve the right to access a charge. A broken appointment fee must be paid before future appointments can be made. The fee is determined as **$1.00 per minute** for however long your appointment was scheduled. We do reserve the right to limit patient care to emergency treatment only in the event we have an unpaid missed appointment fee.

If a patient has multiple broken appointments, all future appointments will only be able to be scheduled if the patient calls the day we happen to have an opening available for the appointment you want to schedule **OR** if you would like to schedule for a future appointment date, the amount of the appointment is paid in full **upon scheduling**.

If your appointment is scheduled on a Monday or a day following a holiday, please call within 24 hours to change or cancel your appointment and leave a voicemail to notify us of this change.

A reservation fee is paid upon scheduling an appointment that will last over the length of one hour and it will be applied to the specific appointment scheduled. The fee is determined as **$1.00 per minute** for however long your appointment is scheduled.

The only time the reservation fee **is not** applied to the appointment, is if the appointment is cancelled with a less than 24 hours notice (unless noted otherwise) or you don't come to the appointment at all.

Should that happen, the Smile Institute of Family Dentistry reserves the right to keep the reservation fee paid and it would have to be paid again to reschedule the appointment(s).

Signature: ____ Date: ________________________

THE SMILE INSTITUTE OF FAMILY DENTISTRY
7712 West Good Hope Road
Milwaukee, WI 53223
PHONE: (414) 760-2000 // EMAIL: office@sifamilydentistry.com
WEBSITE: www.sifamilydentistry.com

INFORMED CONSENT and HIPPA PRIVACY

Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: ____ Preferred Name: ______________________
(please print FIRST & LAST name)

The above listed "Patient" or "Patient's Legal Representative", have been presented with the Notice of Policy (the "Policy" of The Smile Institute of Family Dentistry, (the "Provider"), and have been offered a copy of such policy to keep for my records.

_____ I hereby acknowledge that I have read the Policy and understand its terms and conditions.

OR

_____ I hereby refuse to acknowledge receipt of the Policy and refuse to read or acknowledge any of the terms and conditions of the Policy. I understand that even though I may refuse to sign this acknowledgement, the Provider may still provide treatment to me.

I hereby authorize my treating dentist, and whomever she designates as her assistant and/or hygienist, to perform upon me those dental procedures which we have discussed and I have accepted in the treatment plan. If any unforeseen condition arises in the course of these designated procedures calling in their judgment for procedures in addition to or different from those contemplated, I further request and authorize whatever she deems advisable.

I consent to the treatment plan I have accepted after having been advised of alternate plans of treatment available.

I am informed and fully understand that there are certain risks in any dental treatment. These risks include but are not limited to: post treatment pressure and temperature sensitivity, pain or throbbing nerve (pulpal) inflammation, fracture of new fillings due to early biting pressures, tenderness of abutment teeth, tenderness of tissues under removable dentures, post operative pain, throbbing, swelling and infection, fracturing of files or the crown portion of the tooth during and following root canal therapy, sensitivity of the teeth and gums during and following dental cleanings.

I further consent to the administration of any drugs that are deemed necessary in my case, including, but not limited to: local anesthetics, antibiotics, and analgesics. I understand that there is slight element of risk inherent in the administration of any drug or anesthesia. The risks include, but are not limited to the following complications: adverse drug response (e.g. allergic reactions), cardiac arrest, thrombophlebitis, aspiration, pain, discoloration, seizure, injury to blood vessels and nerves which may be caused by injections of any medication, drug or anesthetic.

I am aware that in spite of the possible complications and risks, my treatment is necessary and desired by me. I realize that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the result of the procedures.

Signature: ____ Date: ___________________________

THE SMILE INSTITUTE OF FAMILY DENTISTRY
7712 West Good Hope Road
Milwaukee, WI 53223
PHONE: (414) 760-2000 // EMAIL: office@sifamilydentistry.com
WEBSITE: www.sifamilydentistry.com