FINANCIAL POLICY

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. Please keep in mind that all fees will be collected at the time of your appointment. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care that you need and deserve. Dental treatment is an excellent investment in an individual's medical and psychological well being. Financial considerations should not be an obstacle to obtaining this important life enhancing care. We are always available to answer your questions or assist you in any way we can.

Payment Options:

For our Non-Insured Patients:

- For larger procedures we are happy to offer a payment plan.
- We also offer Care Credit as an alternative financial policy.
- Payment may also be made using Visa, MasterCard, Discover, or American Express, we do also accept personal checks with Tele Check authorization.

For our Insured Patients:

We will be happy to submit dental claims to your insurance company; however, we can make no guarantee of coverage or payment. **Since the policy is an agreement between you and your insurance company. all patients are responsible for all charges, co-insurances, or non-covered services.** Please know that we will do everything possible to see that you receive the full benefits of your policy.
Estimated co-insurance amounts are due on the day of treatment and are not subject to the courtesy.
For large treatment plans, financing with Care Credit is also available.

Missed Appointments:

When we make your appointment, we are reserving time for your particular needs. We asked that if you must change an appointment, please give us at least 24 hours notice. This courtesy makes it possible to give your reserved room to another patient who would like it.
There is a $50.00 charge for not showing up for scheduled appointments or do not give 24 hours notice will be subjected to the charge.

Billing :

If at time of service, any balance that is not paid full may be subjected to a billing and processing fee.

Additional Terms:

Please note that returned checks will be subjected to a processing charge of $35.00

I have read the above and understand the financial policy of Dr. Ana M. Arango.

_____ _____

(Signature of Patient or guardian if under 18) Date
(Printed name of Patient or guardian if under 18)

DENTAL INSURANCE

Your dental health is our primary concern. Maintaining a relationship with you for many years is important to us. Because of our commitment to your dental health, we will make treatment recommendations based on the condition of your teeth and how at risk you are for dental disease(s). We are serious about helping you reach the highest level of dental wellness possible.

We do not base our examination on your insurance coverage. Your insurance company does not do a comprehensive dental examination so they do not base their coverage on your needs, they base it on a contract made with your employer. Insurance may or may not provide benefits for the treatment recommendations that are outlined for you.

• Most insurance companies have a yearly maximum. The amount most commonly seen is approximately $1000. If your needed treatment is beyond the normal healthy level, don't expect a lot from your dental insurance.

• Please review your dental benefits booklet so that you understand what your insurance will cover. Patients often expect their insurance to cover "everything" only to find that is not the case.

• It is rare that the insurance company will cover any procedure 100%. There are some procedures that they will not cover at all. They are excluded from your plan and **NO APPEAL LETTER OR PLEA FROM THE DOCTOR WILL CHANGE THIS.**

• Usual and Customary tees are fees that the Insurance company states are the average for the geographical area we are in. We have not found that to be the case. We have more often found them to be the lower end of the fee scale for the area. So, we ask that you be aware of your fee schedule.

As part of our service, we will submit your original claim once. If it is retuned for any reason, other than a request for supporting radiographs, we will forward any insurance correspondence to you so you may follow-up directly with your company. Please help us with this service by providing updated personal and insurance plan information.

You are responsible for your account despite insurance coverage. Payment is expected at the time of service. Should you have any questions regarding your insurance coverage, please contact your employer or insurance company directly.

Patient's signature:_____ Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Authorization Form for Use or Disclosure of Patient Information

Date:_____

Patient Name:_____DOB: _____

Address:_____

Home #:_____ Cell #: _____

As required by the privacy regulation, this practice may not use or disclose your protected health information except as provided in our Notice of Private Practices without your authorization.

Additional Contact Information

Name Phone Relationship to Patient__

_____

_____

I give Ana Arango DDS, PC permission to leave detail messages, on my home voice mail or cell phone.
Please circle: YES or NO

My signature verifies that this request accurately reflects my wishes. I understand that this form is valid from the date of signature. It is my responsibility to notify Ana Arango DDS, PC of any changes on this form.

Signature: Date:

Refusal to Sign Only

I understand that if I do not sign this document it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected health information.

Refusal to sign Signature: _____ Date: _____