Financial Policy

As a condition of the treatment performed by the Providers of the office; Payment must be made in full at the time service is rendered. The practices' vitality depends upon payment for services as rendered and it is the responsibility of the patient/patient parent-guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended; at the management's discretion; for payments in full with cash or money order. (Inquire for more details)

Payment for services rendered is due at the time of treatment. Patients with insurance will be given an estimate based on insurance benefits that have been provided, and as a courtesy to you we will bill your insurance company at the time of completion. The patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement.

This dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a co-insurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination.

I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment In consideration for the professional services rendered to me by the Doctor; at the providers' recommendation or at my own request; I agree to pay, therefore, the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered.

I further agree that the reasonable value of said services shall be as billed unless objected to; by me, in writing, within the time allotted for payment thereof.

I also agree, if account should be sent to a collection agency, to pay all costs incurred by the collection agency to pay off account.

I grant my permission to Dr. Paape and/or Dr. Paape's financial coordinator, to telephone me at home or at my place of business to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

_____

Signature of Patient, Parent or Guardian Date

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. David Paape, LLC all insurance benefits, if any, otherwise payable to me for services rendered.

I understand I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Cancellation Policy

Appointments represent time set aside by Dr. Paape to address your specific dental needs so we ask that you be courteous of his time. We require 24-hour notice for all cancellations of appointments. We are happy to accommodate large families, and understand it is sometimes most convenient to come at the same time. Family appointments are usually larger blocks of time, so please allow as much notice as possible if you have to cancel. If you fail to give our office 24-hour notice before cancelling, then a $25.00 fee (per person) will be assessed to your account. This fee will not be covered by your insurance.

We understand that unforeseen circumstances may arise which may prevent you from keeping your appointment, but please give our office as much notice as possible.

Cancelling or missing appointments more than two times, without giving 24-hour notice, will result in only being an “on call” patient. Meaning that we will not hold blocks of Dr. Paape’s scheduled time for you, but you can call in on days you are available to see if we have openings.

Authorization for Release of Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient’s consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Northstar Dental/Dr.David J. Paape, LLC to release my medical and/or billing information to the following individual(s):

1._____Relation:_____

2._____Relation:_____

3._____Relation:_____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed. I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient. You have the right to revoke this consent in writing.

Signature of Patient, Parent or Guardian Date