Castle Rock Smiles
Pediatric Dentistry

FINANCIAL POLICIES

FINANCIAL AGREEMENT:

Payment in full for all charges is required at the time of visit, unless prior arrangements have been made.

INSURANCE FILING :

The patient is ultimately responsible for payment in full of their account, not the insurance company. We do, however, file dental insurance claims as a courtesy to our patients. We can only make estimates regarding your insurance benefits based on the information provided by you and the insurance company. In the event that your insurance company does not pay as much as expected, the remaining balance is due and payable immediately by you, the patient.
INITIALS: _____

ASSIGNMENT OF INSURANCE BENEFITS :

I hereby assign directly to Castle Rock Smiles Pediatric Dentistry dental insurance benefits for any and all dental work done by Dr. Benzley and/or his support staff. I further authorize Castle Rock Smiles Pediatric Dentistry to release, to my insurance company, any and all information relating to the submittal of dental insurance claims.

DELINQUENT ACCOUNTS:

All delinquent accounts (30 days or older) may be subject to reasonable service charges and/or legal interest rates.

FAILED APPOINTMENTS:

Failed appointments (less than 48 hours notice) are a significant contributor to rising dental and health care costs. Individuals who fail to show for a confirmed appointment may be assessed a fee based on the length of the missed appointment.

By signing this consent you state that you understand the agreement and that you agree to the contents of the agreement, and agree to comply with all policies.

Signature of Parent/Responsible Party: _____ Date: _____

Patient Name: _____

HIPAA NOTICE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please note that there is a laminated copy of the NOTICE OF PRIVACY PRACTICES located on the front desk for you to review. By signing this agreement I acknowledge that I have received a copy or have been given the opportunity to read the Castle Rock Smiles Pediatric Dentistry Notice of Privacy Practices, HIPAA Notification.

Signature of Parent/Responsible Party: _____ Date: _____

Patient Name: _____