

Texas Dental, P.A.
Dr. Andrew S. Lazaris, D.D.S.
Dr. Wilson W. Lo, D.D.S.
Dr. Shane A. Ricci, D.D.S.

Financial Policy

Payment in full the day of service is appreciated. There is a fee for all serviced performed in our office, including x-rays. A charge of \$75 per hour will be applied to all broken appointments without 24 hours notice. Tardiness may prohibit the staff's ability to perform all procedures as scheduled and another appointment may need to be scheduled to complete treatment. Your estimated co-payment must also be paid for the day of service. We gladly accept Visa, Master Card, Discover, American Express, cash and personal checks. The undersigned hereby authorizes the doctor to take x-rays, study models, photographs to make a thorough diagnosis of the patient's orthodontic needs. I understand that where appropriate credit bureau reports may be obtained. Any balances due after 60 days shall be considered to be in default and the entire balance shall be deemed to be immediately due and payable. Further, the amount due may be turned over to an attorney for collection. *I agree to pay all costs of collection, including any attorney fees.*

We are happy to help you by filling your insurance claim, at no charge to you, the day of service. It is however your responsibility to follow up with your insurance company to assure prompt payment in order to avoid late payment due to mishandled claims. *I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.*

I hereby authorize payment directly to Texas Dental, P.A., Dr. Andrew Lazaris, D.D.S., Dr. Wilson Lo, D.D.S. & Dr. Shane A. Ricci, D.D.S. of the dental benefits otherwise payable to me. Furthermore, I authorize Texas Dental, P.A. Dr. Andrew Lazaris, D.D.S., Dr. Wilson Lo, D.D.S. & Dr. Shane A. Ricci, D.D.S to provide my insurance company's claim administrators, and consulting health care professional, information concerning my health care, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contract in force on this date, or for two years, whichever is shorter, unless revoked by me. I have received a copy of this authorization and agree that the photographic copy of this authorization is as valid as the original.

If there appears to be a problem with payment of your insurance benefits, or you meet with unexpected difficulty in meeting your financial obligation with our office, please let us know as soon as you suspect that there is a problem. Early communication between you and our office can often allow insurance problems to be alleviated prior to the 60 day deadline, and may also allow us to help you meet your obligation without action outside this office.

I have read and understand the above information.

Patient or Authorized Person's Signature

Date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- ❖ Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- ❖ Obtaining payment from third party payers (e.g. my insurance company);
- ❖ The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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