Muncie Dental Care &
Denture Center

1804 W. McGalliard Road
Muncie, IN 47304
ph 765-282-5655
www.mymunciedentalcare.com

Financial Agreement and HIPPA

Forms of Payment

Payment is expected at the time of service. You may choose from any of the following (including and combination thereof): Cash, Cashier's Check, Person Check, Money Order, MasterCard, Visa, Discover or American Express. If longer payment terms are needed, please ask our staff about financing options through Care Credit.

Insurance and Billing

Our practice accepts ALL Insurance plans including Indiana Health Coverage Program (Indiana Medicaid). We will contact your insurance company and inquire about the dental benefits selected by you or your employer. In addition, we will assist you in maximizing your insurance benefits and file your insurance claim(s). We provide these services as a courtesy to our patients free of charge.

Depending on the type of dental coverage you or your employer selected, we will estimate how much your plan will cover for your dental services. Some insurance companies cover as little as 0% of some dental services and as much as 100% of other dental services.

At the time of service, you will be asked to pay your estimated co-payment and or you're deductible. Please keep in mind the co-payment amount is only estimated and based on information available to us at the time of service. Once your insurance company has paid the claim(s), **any difference will be due on receipt of our statement to you.**

Financial Obligation

The Financial obligation for dental treatment is between you and our office. Our experienced staff will call your insurance company and file all necessary claim(s) and pre-authorization(s) on your behalf. However, your insurance coverage is between you and your insurance company. Once your insurance company has paid the claim, any difference will be due on receipt of our statement to you unless other arrangements have been made in writing. If for any reason, we have not received your insurance company's payment to us within 60 days after the claim(s) have been submitted, the entire balance will be due and payable by you on receipt of our statement.

Last minute cancellations and no show are discouraged. Please understand that such changes affect not only your doctor but the entire facility and other patients as well. If you need to reschedule your appointment please call our office at least 36 hours prior to your appointment. This will allow another patient the opportunity to be seen for dental treatment. Repeated failure to notify the office within 36 hours prior to the scheduled appointment may result in **$25.00** fee being charged.

If my account with Muncie Dental Care & Denture Center should become delinquent, I will be responsible for all costs of collection, including collection agency fees, attorney fees, and interest and court costs. Unpaid balances shall also be subject to data transfer of derogatory information about any unpaid balance to our office to any or all credit bureau reporting agencies (Experian, Equifax, and Transunion). By signing below, you expressly authorize any collection agency or attorney involved to not only transmit this information but also request a copy of your personal credit report from any and all of the above referenced credit report from any and all of the above referenced credit reporting agencies.

Patient Signature _____ **Date** _____

Responsible Party Signature _____ **Date** _____

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Patient Consent / Acknowledgement Form / Notice of Privacy

By signing below, you consent to the use and disclosure of your personal Protected Health Information by Muncie Dental Care & Denture Center, our staff, and our business associates for treatment, payment and health care services. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices ("Notice"). You have the right to review our Notice prior to signing this consent. The terms of the Notice may change. If the terms do change, you may obtain a revised copy of the Notice simply by contacting this office at (765) 282-5655 during normal business hours.

You have the right to request that we restrict our uses or disclosures of your personal Protected Health Information that we are otherwise permitted to use for treatment, payment and health care services, although we are not required to agree to these restrictions. However, if we do agree to further restrictions placed on us by you, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your personal Protected Health Information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal Protected Heath Information.

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES AND DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I have reviewed, understand and agree to the content of the Notice of Privacy.

Patient Signature _____ Date _____

Responsible Party Signature _____ Date _____

Please specify the exact reason why the patient chooses NOT to sign the Patient Consent / Acknowledgement Form and Notice of Privacy.

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