

Office Financial Policy

We share your concerns regarding the increasing cost of health care. We believe that you, our patients, expect and deserve the highest quality care we can provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. With this in mind, we would like to share some information with you about our financial policy. We want you to feel comfortable with us regarding your financial and insurance matters and thereby prevent any misunderstanding. We hope you will consult with us if you have any questions regarding our services and our financial policies.

Many people are under the impression that if they have insurance, it is the insurance company who owes the doctor for services. Please keep in mind, the insurance contract is between the patient and the insurance company. Therefore, the patient is responsible for the bill, regardless of insurance coverage determination. As a courtesy to our patients, we are happy to bill your primary insurance for you, however, the responsibility for payment remains with the patient (or insured).

Patients with Insurance. At the time of surgery patients are requested to make an initial payment toward the estimated charges. This amount will be based upon benefit information obtained from your insurance company, including but not limited to your deductible. If you're insurance pays in addition to the balance due on your account, a refund will be sent to you promptly. These refund checks are sent out once per month.

Many insurance plans state that you will be covered up to "50%, 80%, 100%." In spite of that statement, we have found in actuality that many plans may cover less than that depending upon their established "usual and customary fees" and what services they actually cover. Insurance companies use the term "usual and customary" when setting fee limitations on services. Please be aware that some insurance companies will pay a claim percentage based on their "usual and customary fees," not our actual charges. To determine exactly what portion of your bill will be covered by insurance, we will gladly request pre-authorization by your carrier, however, this may require up to four weeks to be processed by the insurance company.

MEDICARE. Russell K. Kirk, D.D.S., is not a participating provider under the Medicare program. Medicare patients are personally responsible for full payment of services received.

TENNCARE. Russell K. Kirk, D.D.S., is a participating provider for the TennCare Program otherwise known as "Doral Dental of Tennessee." Doral patients are personally responsible for any portion not covered by Doral. This portion will be due in full at the time of service along with any co-pays required by Doral.

Patients without Insurance. Patients without insurance are required to pay the charges at the time of surgery, unless other arrangements are established.

Charge Cards. Visa, MasterCard, Discover and American Express may be used for payment on your account.

Patient Financing. We participate in programs that allow patients to finance their treatment through third party lenders. If you are interested in this service, please ask the business manager.

Hospital Surgery. We require pre-authorization for all hospital surgery. Financial arrangements for hospital surgeries are made on an individual basis with our business manager before your scheduled surgery.

Checks. There will be a \$25.00 charge for all returned checks.

Account Balances. The balance on all accounts is due in full in 60 days regardless of insurance coverage or anticipated payment from other sources. In the event that payment for our services is not made within 60 days of receipt of services, an interest charge of 1.5% per month will be added to the account (18% per annum.) Therefore, patients with insurance whose claims have not been paid within 30 days should contact their insurance company to determine the reason for delay of payment. Delinquent accounts will be referred for collections at the discretion of the business manager. I, the guarantor, agree to pay all costs of collection and attorney fees incurred by Russell K. Kirk, D.D.S., P.C., or their assigns.

Assignment and Release. For individuals with insurance/Medicare, your signature below hereby authorizes your insurance benefits to be paid directly to the doctor. You are still financially responsible for any balance due. It also authorizes the doctor to release any information required for payment and processing of this claim. Signing below you understand/agree to the above.

(Please Print Name)

(Signature of Patient or Legal Guardian)

Witness

Date

Acknowledgement of Receipt of Notice of Privacy Practices

Privacy of Information and Authorization to Release Information. It is the policy of Russell K. Kirk, D.D.S., P.C. to maintain the privacy of all patients' transactions. Russell K. Kirk is hereby authorized to release any medical or incidental information that may be necessary for either medical care or in processing requests for financial benefit. A copy of our Privacy Policy is available for your review.

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

(Please Print Name)

(Signature of Patient or Legal Guardian)

Date