University Dental Associates

Michael E. Kramr, D.D.S. Brian J. Spence, D.D.S. Steve P. Urso, D.D.S.
4011 South Texas Avenue
Bryan, TX 77802
(979)846-0353

Financial Policy

Thank you for choosing University Dental Associates. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:
You can choose from:

- Cash, Check, Visa, Mastercard or Discover Card
- Convenient Monthly Payment Plans[1] from CareCredit
    - Allow you to pay over time
    - No annual fees or pre-payment penalties

Please initial each of the following items:

1. _____ If we participate with your managed care plan or you have a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:
    - The annual deductibles
    - Co-payments
    - Charges for non-covered or cosmetic services

    We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be billed if:
    - Your insurance company pays less than what we expected
    - We obtain a denial from your insurance company
    - We have not received payment from the insurance company within 60 days of our filing your claim
2. _____ If you have no dental insurance, payment is expected in full at the time of service.
3. _____ There will be a $25.00 service fee charged to your account if your check is returned by your bank for any reason. Upon notification from our office or your returned check, payment of the entire balance is due immediately.
4. _____ If you purchase dental products or supplies from our office, please understand that these products/supplies are a non-refundable item. In the event the product/supply is defective, we will gladly replace the item. Some items may only be replaced by the manufacturer.
5. _____ We kindly request that you give us 24 hours notice if you are unable to keep your appointment. Failure to give 24 hours notice will result in a $35.00 missed appointment fee. This fee is <u>not</u> covered by your insurance plan.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

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Informed Consent

The purpose of this form is to help you be aware of the possible, but unexpected events which may occur from a dental visit. It is neither a contract nor a release from any malpractice by the dentists at University Dental Associates.

All dental and anesthetic procedures have associated risks. These may be, but are not limited to:

- Drug reactions and side effects
- Damage to adjacent teeth or fillings
- Post-operative infection
- Post-operative bleeding that may require additional treatment
- Delayed healing of an extraction site (dry socket) necessitating additional treatment
- Sinus involvement when removing upper molars which may require additional treatment or surgical repair at a later date
- Involvement of the nerves during removal of teeth resulting in temporary, or possibly permanent numbness or tingling of the lip, chin, tongue, or other areas
- Bruising, swelling, sensitivity, or pain
- Failure of dental procedure necessitating additional treatment
- Breaking of dental instruments inside tooth canals making additional treatment necessary
- Complications during treatment necessitating referral to a specialist

I understand the recommended treatment for my condition, the risks of such treatment, any alternatives and risks, as well as the consequences of doing nothing.

Please sign below to indicate that you have read the preceding document and that with this understanding you are giving University Dental Associates permission to perform the treatment or treatments discussed and verbally agreed to with the dentist or staff.

Patient Name: _____

Patient Signature: _____

Date: _____

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Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of out Notice of Privacy Practices due to the following reason:

- o The patient refused to sign
- o Communication barriers
- o Emergency situation
- o Other