ROCKCANYON DENTISTRY

Dr. Joseph D. Kayne & Dr. Eric I. Tidwell

THE FACTS

• Please understand that we are desirous to extend care to you and to work with you and any insurance coverage you may have. Professional services are rendered to the patient, and not to the insurance company. Thus, the insurance company is responsible to the patients, and the patient is responsible to the doctor. We cannot render service on the assumption that the charges will be paid for by an insurance company.
• For your convenience we will estimate the portion of your total fee that your dental insurance company will cover. This is just an estimate. After insurance benefits, you are responsible for any unpaid balance. We will ask you to bring the estimated uncovered portion of the total fees to be paid at the time of treatment.
• If you desire to know exactly what your insurance coverage will be, prior to treatment, then we can pre determine or pre-authorize your benefits. However, this delays treatment 4-6 weeks, waiting for the insurance company to respond.
• Our policy requires a percentage of the fee to be paid at the time of treatment if a patient has Dental Insurance. Payment options include: Cash-Check-Visa-MasterCard-American Express-Care Credit. Full payment is required at the time of treatment, if there are no insurance providers or if there have been no payment arrangements made with Rock Canyon Dentistry
• Unfortunately, trends show that insurance benefits will almost always be less than anticipated. Please understand that the amount of benefits to be derived under your particular policy is pre-determined arrangement between your employer and the insurance company; we are unable to increase benefits beyond that which this agreement allows. You however are entitled to discuss employee benefits with your employer to make recommendations for a change from a more competitive policy and provider.
•Should your account be turned over for collection, the undersigned agrees to pay all costs to collect the debt, including, but not limited to, interest in the amount of 18% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party debt collection agency.
• Notice of missed appointment fee-Our office policy requires that you please provide us a 24hour notice to cancel or reschedule your appointment. If multiple appointments are missed a fee will be accessed before scheduling your next appointment.
Thank you for your understanding in this matter.

Patient's name (please print) **Signature** **Date**
_____/_____/_____

HIPAA CONSENT

*Purpose of Consent- By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.
*Notice of Privacy Practice-You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information , and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practice as described in our Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
*Right to Revoke- You will have the right to revoke this Consent at any time by given us written notice of your revocation submitted to the contact person listed below. Please understand that revocation of this consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent. HIPPA compliant representative: 801-373-6362

Signature- I_____ , have had full opportunity to read and consider the contents of this consent form and our Notice of Privacy Practices. I understand that, by signing this consent form, I am given my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.
****** My mobile phone number is. (____)_____-_____**
_____ (Please initial). I authorize the use of my mobile phone number (listed above) to receive scheduling and billing messages. I agree to update this office if my mobile number changes.

Patient's name (please print) **Signature** **Date**
_____/_____/_____