LIBBY DENTAL

Inspiring Health & Happiness

About your Insurance

Libby Dental understands how important insurance benefits are to you. **Please be informed that dental insurance is a contract between you and your insurance company, as a courtesy we will assist you with filing your insurance claim(s).** Your Dentist is providing the highest quality of care for you and your family regardless of insurance frequencies, limitations and/or restrictions. Please be aware that your insurance has a yearly maximum and anything over that will be your responsibility. If dental services have been provided for you by another provider within your benefit year those fees will count toward your maximum as well. If you have two insurance policies, please be aware, **not all policies will cover remaining portions after your primary insurance has paid. It is your responsibility to provide us with any future changes with your insurance.**

By initialing here _____ ,I acknowledge that I have read and understand this.

Please Initial Here

Financial Agreement

In order to provide you with the highest quality dental care, we provide our patients with estimates of fees before dental treatment. **In the event that your insurance does not pay the estimated amount, you as a patient, parent and/or guardian are responsible for your balance.** It is your responsibility to call your insurance company if they have not paid your claim within 45 days from the date of service. Any balance beyond 45 days is your responsibility, and 10% yearly interest will be applied to your account. We provide payment options as: Cash, Check, Major Credit Cards, Care Credit and Lending Club.

By initialing here _____ ,I acknowledge that I have read and understand this.

Please Initial Here

Appointment Commitment

We appreciate you choosing us to serve your dental needs. We take this responsibility seriously and have qualified staff ready to accommodate you during your reserved appointment time. **If circumstances occur and it's necessary for you to change your scheduled appointment, we request a 2 business days notice. A no call/no show is not acceptable. Please be courteous and call us to discuss the best times for scheduling your appointments.**

By initialing here _____ ,I acknowledge that I have read and understand this.

Please Initial Here

Consent for Use and Disclosure of Health Information/HIPAA

I, _____ , have had the full opportunity to read the Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent for your use and disclosure of my protected health information, to carry out treatment, payment activities and healthcare operations.

Signature of Adult Patient:_____ Date: _____

* If you are signing for a minor please print their name here : _____

My Personal and Account Information May Be Released to:

1. _____ 2. _____

_____

Please Sign and Date