FINANCIAL AGREEMENT FOR RICHARD COTTRELL, DDS

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance to each appointment.

Your **estimated** copayment for treatment, which is the amount not covered by your insurance, is due at the time treatment is provided. Your **estimated** copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Our practice accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Third party, extended payment financing is available upon request and approval.

Returned checks will have a $25.00 handling fee. Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Any delinquent accounts will be referred to Court for legal action. There will be a collection fee of 33.3%, and/or court cost and reasonable legal fees should this be required. You understand if this account is submitted to an attorney, collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, that fact that you received treatment at our office may become a matter of public record.

Additionally, our practice requires a deposit of $20 on all scaling and root planning appointments and any appointment over an hour and a half. The deposit fee will then be applied to any treatment rendered, or forfeited if your reserved appointment is missed or cancelled without giving us our required 48 hours notice.

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

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Print Name of Patient or Responsible Party

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Signature of Patient or Responsible Party Date

PATIENT APPOINTMENT AGREEMENT

RICHARD COTTRELL, DDS

We make every effort to value your time and schedule your appointment just for you.

We truly appreciate your courtesy of giving us 48 hours notice if you have a conflict with your appointment. We are committed to your oral health and by keeping your scheduled appointments allow us to be partners in your dental care.

- I acknowledge my appointment is a reservation.
- I acknowledge I am required to provide 48 hours notice to make any changes to my appointment.
- I acknowledge 7:00 AM and 2:00 PM appointments are considered VIP appointments. Without providing 48 hours cancellation notice, I understand I may not be able to schedule another VIP appointment.
- I acknowledge after 2 appointments in which I do not provide 48 hours notice, I may be required to leave a $20 deposit in order to schedule my next appointment.
- I acknowledge after 3 appointments in which I do not provide 48 hours notice I may not be able to reappoint.

X ____

Patient Signature & Date

ASSIGNMENT OF BENEFITS AGREEMENT FOR RICHARD COTTRELL, DDS

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- We require you to pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

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Print Name of Patient or Responsible Party

____________________________________ ____________________________________
Signature of Patient or Responsible Party Date

NOTICE OF PRIVACY PRACTICES FOR RICHARD COTTRELL, DDS

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 Practices: 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. You may obtain a copy of the Notice of Privacy Practices by contacting Heidi Barnett at Dr. Cottrell's office
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

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

Signature/Date:____

Printed Patient/Parent Name:____
If this Consent is signed by a personal representative on behalf of the patient, complete the following.

Personal Representatives Name:______________________________Relationship:______________

Revocation of Consent
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.
Signature:____Date:_________________