Consent for Services, Financial Policy, and Insurance Authorization

With the introduction of the new Health Privacy Act and the diversity of dental benefit packages, more and more dentists are not accepting insurance as payment. We would like to be able to offer our new and existing patients flexibility in paying for dental treatment with the following options:

Option 1 – Fee for Service ☐

This option allows you to be in control of your insurance benefits by paying in full at each appointment for treatment and being directly reimbursed by your insurance company. This method allows you to keep personal records of all dental transactions, all insurance reimbursements, track maximum allowable benefits and will allow you to be more aware of what your plan does and does not cover. You will not have to worry about having outstanding balances with us. When insurance companies are reimbursing patients, payment usually takes 24 hours to receive (with direct deposit) and one to two weeks via mail. We will send electronic claims for you at every appointment - if this option is available to you from your insurance company.

Option 2 –Express Checkout ☐

Our Express Checkout Program allows us to offer you the convenience of using your insurance plan as a form of direct payment. We submit your claim to your insurance company and have payment come to our office. **You would pay the balance of the EOB** (Explanation of Benefits) at the time of service. Secondary Insurance would be submitted at that time as well. Any outstanding balances would then be charged to your credit card. Please complete the information below. It will be kept confidential and used only under the agreed terms.

Patient Agreement

I agree to the **FINANCIAL RESPONSIBILITY** for the following:

THE OUT OF POCKET PORTION AND BALANCE NOT COVERED BY INSURANCE.

I (Name) ___________________________________ authorize Dr. Boisson to keep my signature on file and to issue a credit or debit memo to my credit card account for any over and under payment once my insurance portion is received. I will be notified by phone or mail if any charge or credit is in excess of $300.00. A receipt for this transaction will be mailed with a paid statement.

Payment by: MasterCard/Visa (Circle one)

Credit Card Number: _____________________________________ Expiration Date: _______________

Name on Card: ___________________________ Signature: ___________________________________

Dental Office Personal Information Consent Form

We collect information from our patients such as names, home addresses, work addresses, home telephone numbers, work telephone numbers, and e-mail addresses (collectively referred to as “Contact information”). Contact Information is collected and used for the following purposes:

To open and update patient files.

To invoices patients for dental services, to process credit card payments, or to collect unpaid accounts.

To process claims for payment or reimbursement from third-party health benefit providers and insurance companies.

To send reminders to patients concerning the need for further dental examination or treatment

To send patients informational material about our dental practice.

Contact Information is disclosed to third party health benefit providers and insurance companies where the patient has submitted a claim for reimbursement or payment of all or part of the cost of dental treatment or has asked us to submit a claim on the patient’s behalf. Financial information may be collected in order to make arrangements for the payment of dental services.

Patient’s Medical and Dental Information is collected and used for the purpose of diagnosing dental conditions and providing dental treatment. Patient’s Medical Information is disclosed to third party health benefit providers with patient consent. To other medical and dental professionals with patient consent

If we are ever considering selling all or part of our dental practice, qualified potential purchasers may be granted access as part of the due diligence process to patient information in order to verify information important to the potential sale. If this occurs, we will take steps to ensure that the prospective purchaser safeguards all personal information. Dentists are regulated by the Alberta Dental Association and College which may inspect our records and interview our staff as part of its regulatory activities in the public interest. I consent to the collection, use and disclosure of my/my dependent’s personal information as set out above:

PatientName____________________________________Parent/Guardian________________________

Date____________________________ Signature____