HIPPA & FINANCIAL POLICY

Thank you for choosing Olson-Bieri-Christensen as your dental provider. We are committed to providing excellent care for all your dental needs. We want you to be aware of our expectations concerning the financial aspect of your visit. Please sign this form after you have read it through.

**All patients must complete our health history, insurance and HIPPA forms before seeing the Doctor.
**Co-Payments are due at the time of the service.
**We accept cash, checks, credit cards and Care Credit.
In case of **returned checks, we will only accept; credit cards, money orders, or cashier checks on date of service.
**We will provide an estimate for your dental work upon request.

Regarding Insurance
We are not responsible for how individual policies are processed and paid other than those companies we are contracted with. It is a contract between you, your employer, and the insurance company. If you have questions about your benefits or how your claims will be paid, you need to contact them before you come. We will assist you with any questions. We cannot bill your insurance company unless you give us correct information. Any account sent to a collection agency will be assessed any additional service fees and you will bear the cost of collection and/or our costs and reasonable legal fees, should this be required.

Usual and Customary Rates
We are committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Minors
The adult accompanying a minor, and the parents (or guardians of the minor) are responsible for payment. Co-pays or percentages of the total payment are due at the time of service.

Divorce Decrees
This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests on the accompanying adult.

Insurance Authorization
I authorize the release of any information relating to dental claims and authorize payment directly to Olson-Bieri-Christensen.

Consent for Services
I give my consent to the attending dentist to render to me the dental treatment we have agreed is necessary for myself.

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I HAVE READ, UNDERSTAND AND ACCEPT THE ABOVE POLICIES OF THIS OFFICE.

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 and Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

1) Provide and coordinate my treatments among a number of health care providers who may be involved in that treatment directly and indirectly.
2) Obtain payment from third-party payers for my health care services.
3) 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. I have been given the right to review and receive a copy. I understand that my dental provider has the right to change the Notice of Privacy Practices and I can call the office to obtain a copy of current policy.

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.

Signature: