FINANCIAL POLICY

(Please read this completely. It is important that you understand this policy and discuss with us any questions regarding this policy.)

PAYMENT IS EXPECTED AT THE TIME OF SRVICE:
Please be advised that regardless of insurance status, you are ultimately responsible for the balance on your account. Payment is required at the time services are rendered including applicable deductibles, coinsurance, and co-payments. We accept cash, VISA, MasterCard, Discover, debit cards, and personal checks (there is a $40 service charge for returned checks). If you are unable to meet your financial obligation at the time of service, please do not expect to be seen, your appointment will be rescheduled.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment. If it becomes necessary to forward your account to a collection agency or attorney for the purpose of collection, in addition to the amount owed, you will be responsible for any expenses incurred in collection your account

INSURANCE:
You are responsible for providing us with current and accurate insurance information. We will submit a bill on your behalf to your insurance company for services provided. You are expected to pay your deductible, coinsurance and co-payment at the time of service. We can only estimate the amount you owe at the time of service based on information we receive from your insurance company. We do not guarantee what your insurance will pay towards your treatment and what your estimated portion will be for your treatment. It is ultimately your responsibility to know your coverage. You are also responsible for all charges not covered by your insurance.

You authorize Dr. Conaway to release information required to process your insurance claim. You authorize payment, directly to Dr. Conaway, benefits otherwise payable to you, but not to exceed the charges shown.

If you need assistance or have questions regarding your balance, please contact our office at (228)467-4670.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Missed appointments represent a cost to us and an inconvenience to our patients who could have utilized that time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-cancelled appointments. Excessive missed appointments or late cancellations may result in dismissal from the practice.

I have read and understand this Financial Policy.

Signature (Parent signature if patient is a minor) Date

Frank L. Conaway Jr., D.M.D., P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, (please print your name) _____, have received a copy of this office's Notice of Privacy Practices explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).