Dr. J. Bradford Smith, D.D.S.
Family and Cosmetic Dentistry

Financial Agreement and Office Policies

Thank you for choosing us as your *dental* care provider. Dr. Smith and his staff are dedicated to providing you and your family with the best possible care and service. Understanding our financial agreement is an important part of your care and treatment.

- Your estimated patient responsibility (co-insurance and deductible) is due in full at the time of service.
- We accept cash, checks, money orders, Visa, MasterCard, American Express, and Discover and Care Credit.
    - Visa, MasterCard, American Express, and Discover payments can also be processed over the phone.
    - Care Credit requires that payments be made in person by the cardholder. Cardholders are also required to show proof of identification (ID).

Insurance:

By providing your insurance information, you have agreed to be responsible for services provided. It is very important that you know the terms of your plan, including benefits, limitations, co-insurance, deductible, remaining max and out of pocket expense before each scheduled appointment.

We will file most insurance claims regardless of your insurance plan. We are in-network providers with ***BCBS Grid Network, BCBS State Dental Plus, BCBS Federal, FEP Blue, Companion, and Delta Dental Premier***. However, insurance balances which are not paid within 60 days may be billed to you. Insurance balances are ultimately the patient's obligation.

Any pre-estimate or treatment plan provided to you is not a guarantee of payment. Payment is determined by your insurance company upon receipt of a claim. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

For our self-pay patients, payment is due in full at the time of service.

Past Due Accounts:

If your account becomes past due, we will take necessary steps to collect the balance owed. If your account is 60 days past due, you *will not* be scheduled for an appointment until the account has been paid in full. If we have to refer your account to a collection agency, you are required to pay all of the collection costs which are incurred.

Returned Checks:

In the rare case of a returned check for insufficient funds, we will charge your account for the amount unpaid, plus a processing fee of $30.00. Unpaid returned checks will be forwarded to the Richland County Solicitor's Office.

Separation / Divorce:

In the situation of a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for their treatment fees. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. As always, the person bringing the child to the appointment will be expected to pay as required.

Confirming of Appointments:

We will make every attempt to contact you to remind you of yours and/or your child's appointment. However, your confirmation reminder is a courtesy to you; we encourage you to record the scheduled information on your calendar.

Late Arrivals:

If a patient arrives 10 minutes late from the scheduled appointment time, the appointment may have to be rescheduled.

Missed / Canceled Appointments:

If a patient misses an appointment, or cancels with less than a 24 hour notice from the appointment time, is it our policy to charge $50.00 for the missed/canceled appointment. This fee must be paid before a new appointment is scheduled. We do understand that things happen in life like flat tires, illness, and unforeseen circumstances. If you just let us know, we can help another patient with a dental emergency instead, and you can avoid incurring the $50.00 fee on your account. Patients with multiple missed appointments will be asked to transfer their records to another office.

For additional information, please visit our website: www.jbradfordsmithdds.com.

I have read and understand the financial agreement of Dr. J. Bradford Smith and I agree to comply with its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree such terms may be amended from time-to-time by the practice.

_____	_____	_____
Patient or Responsible Party's Signature	**Print Patient or Responsible Party's Name**	**Date**

Dr. J. Bradford Smith, D.D.S.
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Patient Consent to Receive Mail, E-mail, and/or Telephone Messages

_____

Please Print (Patient's Full Name)

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

_____

Phone Number(s)

I agree that the practice may communicate with me electronically at the following e-mail address:

_____

E-mail Address *(please print)*

Do we have your permission to:

Send a recall appointment reminder to your home?	Yes _____	No _____
Leave appointment, billing or dental information on your answering machine/voice mail/e-mail:	Yes _____	No _____
If needed, confer with other specialists in reference to your treatment plan:	Yes _____	No _____
If needed, confer with your physician or previous dentist to discuss any health/dental concerns:	Yes _____	No _____

I give permission to share appointment, billing or dental information with the person(s) named below:

Name: _____

_____ _____

Signature of Patient/Parent or Legal Guardian Date

If signed by someone other than patient, please specify relationship to patient: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____ _____

Signature of Patient/Parent or Legal Guardian Date

If signed by someone other than patient, please specify relationship to patient: _____

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:

□ Patient / Parent or Legal Guardian refused to sign form

□ Other, Explain: _____

_____ _____

Signature of Office Manager Date