Patient Name ____

Birthdate ____

CONSENT FOR SERVICES, APPOINTMENT AND PAYMENT POLICIES

Hymas Family Dental is happy to take care of your dental needs. Please help us by following our appointment and payment policies.

Broken or cancelled appointments

Please remember that once you have made an appointment this time has been reserved just for you. **We require at least 2 business days notice if a change in schedule is necessary. There will be a $50 fee charged for any appointments cancelled with less than 48 hours notice. This will apply to any failed (no show) appointments also.** This will allow us to schedule another patient in need of treatment and waiting for an appointment at that time. We appreciate your courtesy in this matter.

I acknowledge and understand the cancellation policy ***X*** ______________________________ Date _________
Signature of patient or responsible person

Appointment Reminder & Communication Consent

Important Note: We use cell phone numbers and email addresses to remind patients of future appointments.I consent to Chet A. Hymas, DMD and Hymas Family Dental Employees contacting me electronically by the email address and/or cell phone below for the purpose of receiving appointment reminders, notification that I need to make an appointment, office information and events, dental records, survey regarding dental visit, or reminders of uncompleted treatment. I understand that during the transmission of these messages, the information contained at one point or another may pass through a public network and onto a personal electronic device and as such the transmission may not be secure. However, the practice will not transmit any personal or confidential information about your health, procedures or account status without your permission. (Please note that email messages from our office are encrypted if the message contains any personal health information). I agree to inform the practice if my email address or cell phone number changes. I understand and acknowledge that I can cancel this consent at any time.

I acknowledge and understand the Communication Consent policy ***X*** ______________________________ Date _________
Signature of patient or responsible person

If you would NOT like to be contacted by email or text messages, you may Opt Out of one or both by initialing below.* If you change your mind at any time, you may call us at (509) 994-3824.

_______ I elect to Opt Out of email

_______ I elect to Opt Out of text messaging

*If you choose to Opt Out of electronic communication, what is the best way to contact you?

Home Phone __________________ Work Phone __________________ Mobile Phone__________________

Do you give permission to leave messages on these devices, such as appointment times, pre-treatment estimate amounts, pre-medication reminders (if applicable), etc. Yes ________ No ________

Insurance and Financial Agreement

Our practice is in-network for most dental insurance carriers, and we are a PPO provider. Please provide your insurance card on your first visit, and let us know of changes in coverage or carriers on subsequent visits. As a courtesy, our office files all necessary paperwork with your insurance company; our friendly staff will be happy to help you maximize your dental benefits. Many dental insurance policies have exclusions and limitations that can affect your out-of-pocket cost.

At the time of service, you will need to pay the expected estimated insurance deductible and any estimated amount that we expect your insurance will not cover. Remember that many procedures may not be fully covered; in those instances, you are responsible for the remaining amount. However, please remember that your dental insurance policy is a contract between you, your employer and the insurance company. This Practice is not a party to that contract and therefore cannot guarantee that any or all services will be covered. Please keep in mind that you are responsible for the total amount should your insurance benefits result in less coverage than anticipated. Before proceeding with treatment, we will provide a written estimate of fees. Althoughwe try to get accurate information about insurance benefits and coverage before treatment, we cannot guarantee what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits. Also, some companies take care of claims promptly while others delay payment for several months. After 60 days from the treatment day if payment is not received from your insurance, the payment will be due in full from you and the insurance company will be reimbursing you. Please understand that we cannot accept responsibility for collecting your insurance claim or for negotiating disputed claims between you and your insurance company.

We want you to feel comfortable and confident in all aspects of our Practice. Remember we do not treat according to your insurance. We treat you as an individual and care about your dental health. We are dedicated to providing the best treatment available to our patients.

420 N. Evergreen Rd, Ste 400 Spokane Valley, WA 99216
Tel: (509)922-1360 Fax: (509)922-1260 HymasFamilyDental.com

Insurance claims
If we file an insurance claim for you, at the time of treatment you will need to pay the estimated insurance deductible and any estimated amount that we expect insurance will not cover. We try to get accurate information about insurance benefits and coverage before treatment, but we cannot be sure what the insurance company will pay, if anything, until the claim is submitted and the insurance company actually pays on the claim. It is not unusual for insurance companies to give us erroneous information about coverage or benefits. This is important because you are responsible for all treatment charged, whether or not your insurance company provides any benefits.

Payment is due at the time of treatment
Payment for treatment is due in full at the time of treatment, unless you have made other payment arrangements with us. Please read the next section for an explanation of payment arrangements. However, payment is due at the time of service for the Initial Emergency or Limited appointments.

Payment in Full Payment in full at time of service. Loyalty Discounts may be available for cash pay patients who do not have insurance.
Insurance Co-payment Patient who has insurance pays their estimated portion - due at the time of service.
Care Credit (Good credit standing required)
Free interest up to 6 months upon credit approval
Payment plans up to 36 months
Prepayments can be made anytime without penalty
Fast, confidential service by phone, 1-800-365-8295, or online at their secure website, www.carecredit.com

Estimates
Treatment plans are subject to modification depending on any unforeseen or undiagnosed circumstances that may arise during the course of treatment. The listed fees and insurance reimbursement are **ESTIMATES** only; the final charges will be based on the actual treatment rendered. All professional services are the responsibility of the patient and are charged directly to their account. Your portion is due at the time of service and a finance charge of 1.0% per month will be added to all accounts 90 days past due. The fees quoted are guaranteed for 90 days from date on treatment plan

Returned checks
Please take every precaution to avoid returned checks. It is time consuming for our staff to deal with returned checks and this takes away from the more important job of providing dental services. For this reason, we charge $30.00 for any check that is returned to us without payment. Also, if you have given us a bad check in the past, we will not accept a personal check from you in the future as payment for dental services.

Interest on late payments
Please pay your charges on time. We rely on prompt payment from our patients and their insurance companies. We will charge your account interest at the rate of 1.5% per month (18% annually) for charges not paid within 30 days. We recommend patients understand their insurance benefits and monitor their plans for prompt payment.

Collection costs
We will charge your account for our collection costs if we refer your account to an outside agency or attorney for collection. These costs include the collection agency's commission and, if an account is collected after the start of a collection lawsuit, reasonable attorneys' fees and expenses and court costs. For a referred account that is collected prior to the start of a collection lawsuit, we will add 43% to the principal amount due so that the office will be left with the full principal amount after deducting the collection agency's commission from the amount collected.

Regarding minors in the office
Minors MUST ALWAYS be accompanied by an adult. The adult accompanying a minor will be responsible for payment of services. If parent is giving authorization for a Caregiver, the permission form needs to be completed prior to their visit.

I have read, understand and agree to the above policies and financial agreement. Any questions and concerns were answered fully to my satisfaction. I understand that I am responsible for all fees and/or balances due and agree to pay them in a timely manner in order to avoid any additional charges. I, the undersigned (patient or legally responsible party) hereby assume all financial responsibilities for treatment rendered. Furthermore, I authorize release of any information relating to my insurance claims and the assignment of any and all dental benefits paid directly to Hymas Family Dental, DMD., PLLC. I understand that I am responsible for all costs of dental treatment and any additional costs incurred in collecting this account, including interests, court cost and attorney fees, which may be added to my balance. I agree to the above policies and charges.

X______________________________ Date ____________

Signature of patient or responsible person

Name of patient ______________________________

Name of person responsible for patient charges, if different ______________________________

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