Financial Policy

4001 East Bell Rd Suite 120
Phoenix, AZ 85032
602-992-5600

Thank you for choosing ***Paradise Valley Family Dental LLC.*** Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:
You can choose from:

- Cash, Check, Visa, MasterCard, American Express or Discover
- No interest payment plans through Care Credit (Subject to credit approval)
    - Allow you to pay overtime with NO INTEREST! If paid within the promotional period, otherwise interest assessed from purchases date. Minimum monthly payment required
- Convenient, low monthly payment plans
- No annual fees or pre-payment penalties

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of $500.00 or more.

Please Note:
Paradise Valley Family Dental LLC requires payment in FULL prior to the beginning of your treatment. If you choose to discontinue care before treatment completed, you will receive a refund less the cost of care received. **HAS/FSA/CREDIT CARD refunds will be issued as facility credit only.** All refunds may take up to four weeks to process and will require original receipt.

As a courtesy to our patients with dental insurance we are glad to work with your carrier to maximize your dental benefits and directly bill them for reimbursement for your treatment; however we do request that any co-payments, deductibles, any services not covered by your insurance plan be paid at the time the service is provided. It is patient's responsibility to know their insurance coverage and maximum.
If we do not receive a payment from insurance carrier in 30 days, you will be responsible for payment of your treatment fees and collection your benefits directly from your insurance carrier.

A fee of $75.00 is charged if you should miss or cancel an appointment without a 24 hour notice.
Paradise Valley Family Dental LLC charges a $30.00 for returned check fee and FDCPA (Fair Debt Collections Practices Act) I understand that there will be an additional $25.00 fee per patient to have the office analyze my account. In the event that account collections become necessary, the patient will be responsible for all collection costs including attorney fees of 35% of the pending balance.

I HAVE READ AND UNDERSTAND THE INFORMATION LISTED ABOVE. I HAVE NO FURTHER QUESTIONS.

Patient Name: _____ Signature: _____
Relationship to Patient: _____ Date: _____

HIPPA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA) I , have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly & indirectly.
- Obtain payment form third party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment of healthcare operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restriction.

I understand that I may revoke this consent in writing at any time, except to the extent you have taken by relying on this consent.

Patient name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

AUTHORIZED TO RELEASE PROTECTED HEALTH INFORMATION

I understand that there may be a need to consult with other health care providers. I voluntary authorized: ***Paradise Valley Family Dental LLC*** to use and /or disclose my Protected Health Information (PHI), related to _____ (dental treatment).

The information will be used and/or disclosed for the purposed of _____ (dental treatment). I authorized ***Paradise Valley Family Dental LLC*** to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below.

I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by the federal privacy regulation. I understand that I may revoke this authorization at any time by notifying, in writing, the above named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

Patient name: _____ Signature: _____

Relationship to Patient: _____ Date: _____