Financial Policy – Office of Robert J. Kacmarcik, Jr., DDS

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Prior to treatment, you must complete our patient information and medical history forms, read and approve our privacy policy and submit your insurance card for photocopying. Please ask if you have any questions about our fees, financial policy or your responsibilities.

Your appointment time is reserved exclusively for you. If you cannot keep your appointment, you must provide our office with a 48-hour notice to avoid a broken appoint fee of $50.00.

We will do everything we can to inform you in advance of the anticipated costs of your treatment, including an estimate of the benefit your insurance company is likely to pay. Such information does not preclude the possibility that additional costs may be incurred if unanticipated treatment becomes necessary, nor will it absolve you of your obligation to pay for such treatment. Keep in mind that your treatment needs are not connected to or determined by your insurance benefits.

Insurance is a contract between you and your insurance company. Not all services are a covered benefit in all contracts. We file insurance claims as a courtesy to our patients. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered serviced, "usual and customary" allowances or other issues other than provide factual information as necessary. You, the patient, are ultimately and completely responsible for payment of your account.

Payment for dental treatment is always due at the time of service. Insured patients are required to pay the estimated cost of their care at the time of service. If you do not have insurance, or if your insurance will not reimburse us directly (for example: Delta Dental or Out-of-State Blue Cross Blue Shield), payment in full is expected at the time of service, unless otherwise arranged in advance.

There are payment options available for those who are unable to pay in full at the time of service. These options must be agreed upon prior to treatment being rendered. Please ask a member of our staff to further elaborate.

During the normal course of business we, or our agent, may pull your Credit Report. The purpose of this is to verify identity in an attempt to reduce fraud. This office does not extend credit, so your Credit Score is irrelevant to us.

After 30-days of invoice date, all accounts are subject to interest. Interest at the rate of six and one-half percent per month will be added to your account until the balance has been paid in full. A non-sufficient funds (NSF) fee of $50.00 will be added for each dishonored check. It is your responsibility to pay for any costs of collection including, but not limited to court costs, collection agency and/or attorney's fees, incurred by this office, our agent or our assignee.

If an account is referred to, or purchased by, a collection agency, a fee will be assessed (40% of the outstanding balance) and added to your ledger. In addition, you will be responsible for any fees added by or incurred by the collection agency collecting this debt, including, but not limited to: interest fees at two-percent per month, court costs, US postage, certified mail costs, credit report/skip-tracing costs, courier service and process server fees.

If there is ever a dispute with respect to the amount owed on your account, you must notify this office, in writing, within 30-days of invoice date. For our mutual records, we suggest you send this correspondence via certified mail.

I have read the above policy and understand my responsibility for my account. I, the patient, am ultimately and completely responsible for payment of my account and agree to the above terms.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Completed Printed Name-First/ Middle/ Last Social Security Number

Assignment of Benefits

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Robert J. Kacmarcik, JR., DDS of the benefits otherwise payable to me

_____ _____

Signature of Patient of Responsible Party Date

HIPAA Privacy Form 3 (continued)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Kerri Kacmarcik

Telephone: 302-235-7645 Fax: 302-235-7563

E-mail: dentistKaz@Comcast.net

Address: 5936 Limestone Rd. Suite 201 Hockessin, De 19707

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
A Completed Consent Form will be maintained in the patient's chart.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
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)

_____

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