



Account #: _____ Date: _____

Financial Policy Form

*Thank you for choosing us as your dental care provider. We are committed to your successful dental care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read and sign **prior to any treatment**.*

GENERAL

Understand that, regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes, but is not limited to: dental fees, surgical procedures, tests, office procedures, medications, and any other services not directly provided by the dentist.

EMERGENCY NEW PATIENT APPOINTMENT

Our office is NOT an emergency medical facility. Our practice is focused on providing scheduled, non-life-threatening care and treatment. We are equipped to handle some urgent, non-life-threatening conditions related to our scope of practice (e.g., severe toothache, broken filling). If you are experiencing a medical emergency, immediately dial 911 or go to the nearest hospital emergency room.

If you are a new patient and come to our office with a dental emergency and service is provided, payment for any procedures performed is due in full at time of service. Payments can be made with cash, credit card, or check. If you have dental insurance coverage, we will be happy to file the claim for you so you can be reimbursed by your insurance company.

REQUIRED ADMINISTRATIVE INFORMATION FOR SERVICE

Our office requires all patients to provide government-issued photo identification (such as a Driver's License or Passport) and a Social Security Number (SSN) prior to service as part of our standard patient registration process. This information is collected for the purpose of verifying patient identity, ensuring patient safety, accurately processing insurance claims, and establishing financial responsibility. All information is secured in compliance with the HIPAA Privacy and Security Rules.

Failure to provide a valid government-issued photo ID and/or the patient's Social Security Number constitutes a failure to comply with the essential administrative requirements of this office. Our office reserves the right to decline to establish a patient relationship or to discontinue non-emergency care until the required administrative information is provided. The patient must also understand that a refusal to provide this information may result in the inability of our office to process insurance claims.

MISSED APPOINTMENTS

If you need to cancel a scheduled appointment, we ask that you have the courtesy to notify us at least (24) twenty-four hours in advance. Please help us service you and our other patients better by keeping scheduled appointments and arriving on time.

INSURANCE

Please remember that your insurance policy is a contract **between you and your insurance company**. We are not a party to that contract. As a courtesy to you, our office provides certain services including pre-treatment estimates, which we electronically send to your insurance company at your request. It is not physically possible for us to have in-depth knowledge nor are we able to keep track of every aspect of your insurance coverage. **It is 100% up to you to contact your insurance company and inquire as to what benefits your plan has established for you.** We can assist you to a certain degree depending on the information we are able to obtain. If you have any questions concerning the pre-treatment estimate and/or any fees for services, we will be happy to assist you prior to treatment in order to minimize any confusion. Estimates are predictions of coverage and your actual payment amount may differ.

******Our office is currently NOT IN NETWORK with any insurance providers.******

******However, we accept most insurance as an out-of-network provider******

Please note that some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance on your account is your responsibility, whether or not your insurance company pays any portion.

PAYMENT TERMS

- For new patients who are not Indiana residents, a 100% deposit of estimated services is due at time of service. We will file your insurance claim for you. Any remaining balance must be paid within 30 days of billing.
- For new patients residing in Indiana, a minimum 50% deposit of estimated service is due at time of service. We will file your insurance claim for you. The remaining balance must be paid within 30 days of billing.

Another option is to establish an approved Care Credit account and receive 3 to 6 months of no-interest financing.

REQUESTS FOR MEDICAL RECORDS

Requests for medical records will be granted in compliance with the HIPAA Privacy and Security Rules. Our office reserves the right to assess administrative fees in accordance with Indiana Code § 16-39-9-4. We require that requests for medical records be made in writing and include the patient's name, current address, and specific documents being requested. A valid government-issued photo I.D. is also required.

FINANCIAL ACKNOWLEDGEMENT & AGREEMENT

I have read, fully understand, and agree with the financial policies of this office. I understand that I am responsible to pay my account balance in full. In the event that my account is sent to collections, I agree to pay all collection costs, court costs, and reasonable attorney fees associated with the collection of this debt. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by my insurance.

Signature of Patient: _____ Date: _____

(or)

Signature of Legal Guardian/Responsible Party: _____ Date: _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with

Name of Insurance Company/Companies

and assign directly to Dr. Hirschenberger all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

Signature of Patient: _____ Date: _____

(or)

Signature of Legal Guardian/Responsible Party: _____ Date: _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request

Name of Minor/Child

and authorize the dental staff to perform necessary dental services for my child including, but not limited to, X-rays and administration of anesthetics deemed advisable by the doctor – whether or not I am present at the actual appointment when treatment is rendered.

Signature of Legal Guardian/Responsible Party: _____ Date: _____

