Dr. Ronald E. Terry Family Dentistry

Patient Responsibility Agreement

Patient responsibility Payment is due at time of service

We have several payment options available

Cash	5% discount for treatment paid in full prior to the time of treatment
Credit	All major credit cards accepted
Check	We gladly accept your check; if your check is dishonored or returned for any reason we will electronically debit your account for the amount of the check plus a processing fee of **35.00**.
Care Credit	Please see brochure for details
TSPP	Terry Smile Protection Plan, our in-house dental plan, please ask for details

Appointment Policy

- If you are more than 15 minutes late we reserve the right to reschedule your appointment if necessary.
- If you must reschedule or cancel your appointment a **48 hour** notice is required. If you do not come to your scheduled appointment or cancel your appointment with less the 48 hours notice you may be charged a cancelation fee of $50.00 or 10% of the scheduled treatment.

Patient Visitors Policy

- Patients that have an appointment are allowed one guest during the visit; the guest may remain in the waiting room while the patient is being treated in the operatory.
- **We request that** no children under the age of 12 remain in the waiting room unattended.
- Unless child is being treated by the doctor please do not bring them in the clinical area.

Private Dental Insurance

- As a courtesy to our patients we will file your claims for dental services we provide to you. We require the Patient Responsibility and deductible to be paid at the time of treatment. You are responsible for providing accurate, current insurance information at each visit. Please present your insurance card at each visit. You are responsible for any remaining balance after your insurance company has processed your claim. If your insurance company does not process and pay your claim for any reason after 60 days you will be responsible for the balance.

Payment Guaranty Agreement & Release of Information

- In consideration for services rendered to me or my dependent child, I authorized Dr. Ronald E. Terry to bill my insurance carrier for all services provided and that all payment for services rendered will come directly to Dr. Terry. I give authorization to the release of any information requested by my insurance company with respect to insurance claims. I assume all responsibility for any portion of treatment cost not paid by my insurance company. I agree that **if I do not have insurance or my insurance is not active at the time of treatment, I AM RESPONSIBLE FOR PAYING IN FULL AT THE TIME OF SERVICE FOR ALL TREATMETNT.** If for any reason my account becomes delinquent, I agree to pay an interest rate of 1.5% per month, or 18% annually, on balance more than 60 days old, plus any attorney's fees that may be added.

Acknowledgement of Privacy Practices

- The Health Insurance Portability and Accountability Act of 1996 (HIPPA) provides for the protection of your health information from unauthorized use or disclosure. Our notice of privacy explains how we handle your personal health information. Basically you are agreeing to our use and disclosure of your protected health information ONLY to carry our TREATMENT, HEALTHCARE OPERATIONS, and PAYMENT ACTIVITIES. You may inspect or copy our HIPPA statement. In addition, Dr. Ronald E. Terry and his dental team have my permission to leave appointment reminders on my home answering machine and or cell phone voice mail or email.

I have read and understand the Financial, Insurance & Privacy Policies, and Patient responsibilities as noted in this authorization

Patient/Parent/Guardian: ___________________________________Relationship:_____________________Date:___________