

Financial Policy & Dental Insurance

We are committed to providing you with the best possible treatment. Our patients understand that in order to deliver optimum dentistry, we must maintain our office on sound principles. Therefore, we inform our patients of our financial policies at the very beginning of our relationship to avoid any misunderstandings. Payment for services is due at the time our services are rendered, unless prior written arrangements are made.

Treatment plans are presented to all patients before any work begins. We consult with our patients so that there is full understanding of the procedures before treatment is rendered. If at any time it is necessary to change the treatment plan and additional charges or credits are applicable, this is explained to the patient and agreed to before the services are rendered.

As a courtesy, Concord Center Dental can submit claims to your primary insurance company. Neither financial arrangements, nor treatment recommendations are made based on insurance reimbursement. Insurance coverage is a pact between the patient and their carrier, not between the insurance carrier and the dentist.

Our Beliefs

1. You should decide the quality of the dental treatment you prefer – not an insurance company.
2. The quality level of oral health care and the choice of dental materials used should be determined by you and your dentist, NOT a dental insurance company.

Payment options: For your convenience, we accept a variety of payment methods that include personal check, cash and most major credit cards. Full payment is expected at the time your services are performed. On lab related dental work, not limited to crowns, dentures, and implants, etc. payment is due prior to sending the case to the lab. Failure to pay accordingly will result in delays in sending the work to the dental laboratory and thus the return date.

Insurance: As a service to our patients with dental insurance, we will submit all necessary paperwork to your carrier. Your specific dental policy is an agreement between you and your insurance company. Our business staff will gladly try their best to verify your benefits. On occasion, you will need to discuss the exact details and benefits with them yourself directly. All insurers have different policies and coverage.

Patient is responsible for all costs incurred in the collection of any past due account/fees, including any extra administrative costs, certified mail fees, collection agency fees, attorney fees, and court costs. Interest at 27% APR will be charged on past due amounts remaining after the agreed schedule.

I have read the 'Financial Policy & Dental Insurance' policy from Concord Center Dental and agree to its contents.

Print Patient/Guardian Name

Signed

Date

Cancellation & Rescheduling Policy

We require a cancellation or rescheduling notice of 48-business hours prior to your existing appointment. Business hours are defined as days in which the practice is open, Monday through Thursday, 8:00am -5:00pm. We understand that life sometimes is unpredictable, and as such you may need to change your scheduled appointment. Late cancellations or no-shows will incur a fee of \$50.00 per scheduled hour or part thereof.

Late cancellations and no-shows add to practice overhead, and we feel that some of the costs should be absorbed by those patients who cancel or reschedule at a late notice. We have invested in technology to inform you of your visits via text message, email and phone calls 3 days in advance of your appointment. At Concord Center Dental, we do not believe that patients who routinely come to their dental visits should have to incur higher costs due to those who choose to not show for dental appointments. Many practices offset these costs by passing them on to all their patients. At Concord Center Dental we do not agree to this principal and strive to maintain costs as low as possible for our patients. We seek to treat our patients in a timely efficient professional manner, we strive to make your appointment on time, and we ask the same courtesy from our patients. Appointments may be cancelled or rescheduled via voicemail, or email to admin@concordcenterdental.com. Text messages are not acceptable.

Concord Center Dental reserves the right to limit appointment times provided, and collect a deposit in advance, from patients with a history of two or more no-show or late cancellation visits.

Finally, patients who continue to have a poor attendance history of 2 or more no-show visits, or late cancellations, may be dismissed from the practice at our discretion.

I have read the 'Cancellation and Rescheduling' policy from Concord Center Dental and agree to its contents.

Print Patient/Guardian Name

Signed

Date

Patient Understanding & Informed Consent

Concord Center Dental may use and disclose your health information in connection with our healthcare operations. See 'Notice of Privacy Practices' for a complete description. Prior to receiving dental care, you are encouraged to ask any questions that you may have before you give your consent for dental treatment. All dental procedures may involve risks, unsuccessful results, and complications. No guarantees are made regarding any result or cure. You, as our patient, have the right to be informed of any such risks and potential consequences of not performing treatment, the nature of the procedure, expected benefits, and availability of alternative methods of treatment. You have a right to consent to, or refuse, any proposed procedure at any time prior to its performance. Concord Center Dental also reserves the right to not perform specific treatment requested by a patient.

X-Rays: Dental x-rays, photos and or models will be taken as necessary and appropriate for examinations, diagnosis, consultations, and treatments.

Patients Financial Responsibility: Payment for services is due at the time of the appointment. An estimate of fees and consultations will be provided prior to commencing treatment. Patient is responsible for all costs incurred in the collection of any past due account/fees, including any extra administrative costs, certified mail fees, collection agency fees, attorney fees, and court costs. Interest at 27% APR will be charged on past due amounts which remains outstanding which can be applied from the date the service was provided.

Dental Records: The dental records, x-rays, photographs, models, and other diagnostic aides that relate to your treatments, are the property of Concord Center Dental. You have a right to request a copy of your record, which can be provided with a signed record release form. Concord Center Dental may charge a reasonable administrative fee for this service. A reasonable turnaround time of up to 21 days in order to complete the administrative tasks will need to be provided in order to construct this file. In the case of a record release request, the office protocol needs to be followed in advance of any records being released.

Emergency and after-hours care: Emergency dental care is generally temporary treatment that is intended to provide relief of severe pain and infection for a tooth or area. It is the patient's responsibility to make arrangements for follow-up care that may be required to alleviate or resolve the dental problem.

For after-hour care please call the office on (978) 369-5700 and follow the recorded instructions.

Emergency after-hour care is a service provided for our active and current patients. Active patients are defined as patients of record who are currently patients of the practice and have been seen previously within a 12-month period.

I have read the 'Patient Understanding & Informed Consent' policy from Concord Center Dental and agree to its contents.

Print Patient/Guardian Name

Signed

Date

Notice of Privacy Practices

Our Legal Duty

At Concord Center Dental we are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice went into effect April 14, 2003 with the latest revision August 20, 2013, and will remain in effect until modified or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician/dentist, dental auxiliaries, students and other healthcare providers providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performances, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable

inferences of your best interest in allowing a person to pick up prescriptions, dental supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, domestic violence, or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose, to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to a correctional institution or law enforcement official having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Patient Rights

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must complete our signed record release authorization form to obtain access to your health information. We may charge a reasonable fee for producing dental records and X-rays as allowed by law.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Breach Notification: We will provide you with notification of a breach of unsecured PHI as required by law.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. This request must be in writing. Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. This request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you received this notice on our web site or by electronic mail (e-mail), you are also entitled to receive this notice in written form.

Concord Center Dental

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____ have received a copy of this office's Notice of privacy Practices.
Print Patient/Guardian Name

Signature

Date

Please list the people with whom we can share your information:

For Office Use Only

Reasons for Inability to Receive Signature:

Dental Insurance Coverage Notice and Disclaimer

I understand and agree that Concord Center Dental does not represent my dental insurance company and that Concord Center Dental cannot make any representation or warranty that my dental insurance company will cover any, or all portions of the dental services rendered.

I further understand that I will be billed and that I will be responsible to pay for all amounts not paid or covered by my dental insurance. I realize that bills will include amounts incurred from deductibles, co-insurance, co-payments, and amounts not paid by my dental insurance due to the maximizing of my benefits.

I acknowledge that it is my ultimate and soul responsibility to determine whether a dental service, procedure, or treatment advised is covered by my dental insurer, and if covered, the amount of coverage that will be provided and whether my benefits are exhausted or will be exhausted during the service, procedure, or treatment program.

I acknowledge and understand that Concord Center Dental will not, as a matter of policy, agree to halt any service, procedure, and/or treatment solely because my dental insurance benefits have been maximized and that Concord Center Dental cannot know at what point in my dental care that my insurance has been maximized or running out.

I can confirm that no representation has been made to me by Concord Center Dental that is contrary in any way to this notice and disclaimer and that any statement made by Concord Center Dental concerning my dental insurance benefits cannot be relied upon as a guaranty of coverage. Only you the patient can confirm this by contacting your insurer directly. Concord Center Dental will not act as a messenger between both parties in terms of coverage.

I acknowledge that it is my ultimate and sole responsibility to confirm dental insurance participation which is dependent upon the dentist rendering treatment not upon Concord Center Dental.

As a courtesy, Concord Center Dental will submit claims to my insurer for work in progress or completed. I understand that Concord Center Dental does this as a courtesy on my behalf, and in the event that the insurer fails to make payment within 90 days the fees become immediately payable to Concord Center Dental.

In the event of a patient having multiple dental insurance coverage, as a courtesy Concord Center Dental will submit the claim to your primary insurance provider. We will apply any payments received to your account. I understand that the balance needs to be paid by the patient. We will provide you with the paperwork, statements, and codes for you to seek reimbursement from your secondary insurer.

I have read the 'Dental Insurance Coverage Notice and Disclaimer' policy from Concord Center Dental and agree to its contents.

Print Patient/Guardian Name

Signed

Date