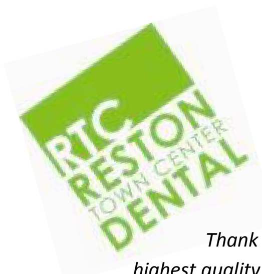

Financial/HIPAA Policy

Thank you for choosing our team of dental professionals to serve your dental needs. We are committed to provide you with the highest quality care. We appreciate the confidence you have placed in us and will do everything possible to continue to warrant your confidence as we serve you. In order to continue providing outstanding care to all of our patients, we ask that you please understand and agree to the following office financial policy.

Insurance:

Dental insurance is designed to help offset the cost of dental care. Insurance estimates provide a table of allowance that will assist you in determining your approximate out-of-pocket expenses.

1. Filing insurance claims is a courtesy that we will gladly perform for you to help you maximize your benefits. However, you are responsible for any amount not covered by your insurance, whatever the reason.
2. On your behalf, we will contact your insurance company to help determine your level of benefits. Please note that insurance estimate and pre-estimates are not a guarantee from your insurance company.
3. Your insurance policy is a contract between your employer and your employer's insurance company, we are not party to that agreement. Our office cannot accept responsibility for negotiating a settlement with your insurance company on a disputed claim.
4. We generally will accept assignment of benefits (payment) from your insurance company but we reserve the right to refuse assignment on certain plans. In that case full payment is due by you at the time of service and your insurance company will reimburse you directly.
5. In the event that you wish to have us invoice your insurance company directly, you are agreeing to the following statement: I request the payment of authorized insurance benefits for any services furnished to me be made on my behalf to RTC Dental.

Missed Appointment Fee: ***RTC Dental does charge a missed appointment fee of $30.00 per half hour of appointment time for all appointments not given at least two business days (48hrs) advance notice.*** Please call us immediately once you realize that you cannot keep your appointment. All missed appointment fees must be *paid prior to scheduling another appointment.*

Payment Policies:

As a condition of your treatment by this office, financial arrangements must be made in advance. We depend upon payment from our parties for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment. We will discuss financial options with you before rendering treatment.

1. If you have dental insurance, you estimated portion of payment is *due in full at time of service,* unless prior written financial arrangements have been made.
2. If you do not have dental insurance, payment for services is *due in full at time of service,* unless prior written financial arrangements have been made.
3. There is a $ 35.00 service charge on all returned checks.
4. I understand and agree that any account balance not paid within 90 days must be subject to collection activity. I understand RTC Dental will retain the services to assist with the collection of any outstanding balance.

HIPAA:

Affiliate Dental Practice "Reston Family Dental Center" located at 1801 Robert Fulton Dr #100, Reston VA 20191:
By signing this form you authorize 'Reston Town Center Dental' and its representatives to share your medical records (and personal identification data) with the affiliate dental company known as 'Reston Family Dental Center which is located at Robert Fulton Dr #100, Reston VA 20191. This will facilitate your care by allowing you to receive dental treatment in both dental offices seamlessly without the need to fill out additional authorization forms each time medical records (such as x-rays) are needed to provide treatment for you in the new affiliate office.

By signing below you are agreeing to all of the terms contained in this Financial Responsibility Agreement and Consent for Services.

Print Patient Name: ____ *(Please Print)*

Signature/Guardian: ____ Date: _____________________

Acknowledgement of Receipt Of Notice of Privacy Practices

** You May Refuse To Sign This Acknowledgement **

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

Please Print Name

Signature(If minor parent or legal guardian signature required)

Date

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request.

I also understand that if I have any question or complaints, I may contact Reston Town Center Dental or Reston Family Dental Center. Or I may also contact our Privacy Officer Dr. Ali Miamee-his direct email address is info@RTCdental.com

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

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other(Please specify)____

Attempt was made by: ____ Date: ______ / ______ /______