3525 25th St S
Fargo, ND 58104
(701) 298-9400
www.designersmilesfargo.com

FINANCIAL POLICY AND HIPAA

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 45 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must provide proof of insurance at each appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, American Express, and Discover. Outside financing is available upon request and approval.

Returned checks and balances older than 45 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Additionally, our office may charge you for broken appointments and appointments cancelled without 48-hour advance notice.

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

I am aware the practice has a Notice of Privacy Practices which is available for my consideration. This notice provides a description of treatment, payment activities, & health care operations as it relates to the usage & disclosure of protected health information.

I consent to the office of Designer Smiles the opportunity to use this information as it relates to the treatment of my dental health.

Signature _____ Date _____

DESIGNER SMILES