Financial Policy

Thank you for choosing Dr. Alok Arora,DMD as your dental care provider. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

REGARDING SERVICES AND REQUEST FOR PAYMENT:

We are committed to providing you the best dental care. Our treatment charges are usual and customary for our area. Your fee for treatment is ultimately your responsibility whether you have insurance coverage or not, and whether your insurance company pays or not.

As a courtesy for our patients who have insurance coverage, we will bill your insurance for dental services received at this office. If you have an insurance policy, it is a contract between you and your insurance company. We are not a party to that contract. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some and perhaps all the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance.

Our policy is payment is due to be paid in full within 45 days of treatment. If the balance for service is not fully paid within 45 days of the visit, and a requested monthly financial agreement for payment is not made with us or routinely followed it is possible that your account may be sent to collections. This office accepts cash, check, Visa/Master card and debit card payments.

LATE NOTICE/MISSSED APPOINTMENTS

Due to the amount of time reserved exclusively for your scheduled procedure, we do request at least 2 working days' notice for cancellation and/or rescheduling of an appointment. It is our policy that if a patient cancels an appointment without giving us 2 working days notice and/or fails an appointment, a charge of $50.00 can be applied for cancellation/failed appointment fee or we may apply a fee based on a percentage of the treatment costs. A deposit fee may be requested to reserve future appointments if an appointment is not cancelled or rescheduled with adequate notice. This fee is the patient's responsibility. Insurance companies are not responsible for this charge.

Thank you for your understanding and review of our Financial Policy. Please let us know if you have any questions or concerns before signing this agreement form.

In signing this form, I have read and understand the Financial and Cancellation Policy and agree to this policy.

_____ _____

Signature of Patient (Parent or Guardian) Date

HIPAA Acknowledgement Form

- I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

  -Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly

  -Obtain payment from designated third-party payers.

  -Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

- I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link HIPAA Notice of Privacy Practices or in office in print form).

  I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Belmont Dental Group has the right to change its Notice of Privacy Practices from time to time and that I may contact Belmont Dental Group at any time to obtain a current copy of the Notices of Privacy Practices.

  I understand that I may request in writing that Belmont Dental Group restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Belmont Dental Group is not required to agree to my requested restrictions, but if Belmont Dental Group does agree, then it is bound to abide by such restrictions.

  I understand that I may revoke this consent in writing at any time, except to the extent that Belmont Dental Group has taken action relying on this consent.
- By checking the box I acknowledge that *

☐ I received and read this organization Notice of Privacy Practices

_____ _____

Signature of Patient (Parent or Guardian) Date

Dental Materials Fact Sheet Acknowledgement Form

- Please visit the following link to download and view Dental Material Fact Sheet
- By checking the box I acknowledge that *

☐ I received and read Dental Materials Fact Sheet

_____ _____

Signature of Patient (Parent or Guardian) Date