SOUTH JERSEY FAMILY DENTAL

WRITTEN FINANCIAL POLICY- UPDATED 2/10/2025

PAYMENT OPTIONS:

We accept cash, checks, Visa, Mastercard, Discover, American Express or Care Credit (which can offer low or no interest monthly plan payments)

*** A $35.00 charge will be applied to your account for returned checks.

*** All accounts not paid in full within 90 days will be submitted to our collection agency.

*** We do offer a 10% senior citizen courtesy for 65 years of age or older and pay for their treatment with cash only. This discount does not apply to seniors who have dental insurance/discount plan (ex. AVS Plan) or our in-house discount plan. Discounts do not apply to any bleaching services or orthodontic services.

For patients with dental insurance- we are happy to work with your insurance to maximize your benefit and directly bill them for reimbursement for your treatment, but the deductible and the ESTIMATED copay are due at the time treatment is rendered. ** If we do not receive payment from your insurance company within 90 days, you will be responsible for payment in full to us and then you are responsible to collect the payment from your insurance carrier.

***Payment is due by completion of your recommended treatment. For larger treatment plans, a deposit is required to book your appointment. This deposit does go towards your co-pay unless you do not show or cancel your appointment within the 24 hours. For 60 minute appointments or longer, a $75.00 deposit is due. For appointments 2 hours or more, a $150.00 deposit is due. _____ (initials)

*** A fee will be charged to patients who do not show for their appointment or cancel less then 24 hours prior to appointment time. **For hygiene appointments, the fee is $50.00 and for doctor appointments the fee is $75.00.** We also understand that life happens- sickness, work conflict, schedule changes, funerals , etc., but please understand that we have this policy because when a patient does not show or cancels too close to the appointment time, we are unable to fill this time slot and we have many patients who are waiting for appointments. _____ (initials)

*** **Please confirm your appointment at least 24 hours before your appointment time**. We send text messages so that you can confirm. We also call- if we leave a message, please call us back to confirm. If we are out of the office, you can leave a voice mail- it is date and time stamped. If your appointment is not confirmed, we do reserve the right to cancel your appointment. _____ (initials)

Patient/Guardian Signature: _____ Date:_____

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HIPAA FORM

HIPAA OMNIBUS RULE - Patient Acknowledgement of Receipt of Notice of Privacy Practices and Consent/limited authorization & release form. *You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims and you would be responsible for paying account in full day of treatment and submitting claim yourself for reimbursement from your insurance to you.*

Date:

The undersigned acknowledges having had full opportunity to read and consider the contents of this HIPAA Consent form and the Notice of Privacy Practices. The undersigned understands that, by signing this consent form, they are giving consent to use and disclose their protected health information to carry out treatment, payment activities, insurance and any other office procedures. A copy of this signed and dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide this information with your knowledge and consent.

_____ Please print patient's name
Patient Signature (if 18 or older)

_____ Parent / Guardian / Legal Representative
Signature
Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step-parents, grandparents, and/or any caretakers who can have access to this patient's records):
Name:
Relationship:

Name:
Relationship:

I AUTHORIZE Contact from this office to **confirm my appointments, treatment, and billing information** via:
Cell Phone Home Phone Text Message My Cell Phone Email Confirmation Any of the Above
I AUTHORIZE Contact from this office to **information about my health** via:
Cell Phone Home Phone Text Message My Cell Phone Email Confirmation Any of the Above

Patient Signature: _____

Date: _____

MEDICATIONS LIST

Patient Name_____

Today's Date_____

Please list any current medications you are taking below:

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