Policy Agreements

Financial Policy Agreement: Payment in full is expected at each appointment. If requested before treatment, we will provide an estimate of charges to be completed.

Patients with insurance: Our office will file with your insurance company as a courtesy. Keep in mind we can only estimate what your portion will be, which is due the day of treatment. You will be billed the difference if the insurance company pays less than the actual bill for service. Regardless of your insurance benefits, you are responsible for charges incurred and remaining balances. It may take up to four weeks for our office to receive insurance payments. If insurance payment is not received in 45 day, we ask that you contact your insurance company.

Broken Appointments: We reserve the right to charge for any broken appointments. Charges for broken appointments with the dentist may be up to $40 if less than one hour. Appointments over an hour can be $60. Broken hygiene appointments will be at a rate of $30. We ask that a 24 hour notice be given for any cancellations. If less that a 24 hour notice is given, it is considered a broken appointment with the exception of an emergency. We also reserve the right to dismiss a patient due to broken appointments.

Confirming Appointments:
We will attempt to confirm appointments a week prior and again two days before. We reserve the right to cancel appointments if it they are not confirmed 24 hours before their scheduled time.

After Hours Policy: Narcotics will not be called in after hour or on weekends nor will narcotics be given when treatment is not rendered.

Authorization and Release

I authorize North Arkansas Dental Group to release any information including the diagnosis and the records of any treatment or examination rendered to myself or my child during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to North Arkansas Dental Group insurance benefits otherwise payable to me.

My signature acknowledges that I have read and understand the policies as stated above and agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.

Patient Signature (or parent of minor)
_____ Date: _____

Notice of Privacy Practices

Our legal Duty
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice of 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 is now in effect, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided applicable law permits such changes. This includes all health information that we maintain, including health information we created or received. 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.

Uses and Disclosures of Health Information
We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatments: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

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

Your Authorization: In addition to our use of your health information for treatment or payment, 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 of 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.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying of 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 the 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, 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 are required by law to report any abuse of neglect to the proper officials. We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or possible victim of other crimes. We may disclose your health information to the extent necessary to avert serious threat to your health or safety, or the health or safety of others.

I have received the North Arkansas Dental Group Notice of Privacy Practices handout provided to me at registration.

Patient Signature (or parent of minor)
_____ Date: _____