FINANCIAL POLICY

In order to assist you in understanding and managing your financial responsibilities as a patient in our office, we have developed the following policy:

1. We are happy to accept cash or personal check at the time of treatment.
2. MasterCard, Visa, Discover and American Express are also accepted.
3. As a courtesy to you, we will file your insurance. (Or, we will provide you with the necessary paperwork to file your insurance. You are asked to pay your part in full at the time of service.) In order to provide this service, we must have a current, accurate copy of your insurance card to keep in your record. **If this is not provided, payment is expected at the time of treatment.**
4. In the case your account becomes delinquent there will be finance charge added after 90 days.

Keep in mind: There are some insurance companies that may not pay benefits to us as a provider. In those cases, you will have to pay in full and be reimbursed. ALL balances of money owed are personal balances ***regardless*** of what the insurance company pays. We will do our best to provide you with information on your managed care plan (if applicable). However, in the end, your insurance is a contract between you, your employer and the insurance company. ***You*** are responsible for any balance at time of treatment.

5. In the case of dependent children (or other dependents), the parent (guardian) presenting the patient to our office will be the person responsible for all balances and transactions for that patient. We will not as an intermediary in these cases.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read and understand the Financial Policy. I understand and agree to this Financial Policy:

X______________________________ Date_______________
Signature of Patient/Responsible Party

Dr. Adam C. Hodges, D.M.D. • Dr. Justin B. Hodges, D.M.D.
1 Vanderbilt Park Dr. • Suite 260 • Asheville, NC 28803
828-274-8088 Fax 828-274-3519

Hodges and Hodges, DMD, PA

Acknowledgement of Receipt Of Notice of Privacy Practices

Patient Name & Address: ______________________________

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I have received a copy of the Notice of Privacy Practices for the above named practice.

______________________________ Signature

______________________________ Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ☐ An emergency existed & a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason: ______________________________
- ☐ Other: ______________________________

Prepared By ______________________________

Signature ______________________________

Date ______________________________