St. Bethlehem Dental Care
Anthony S. Carroccia, DDS, MAGD, ABGD
2088 Lowes Drive
Clarksville, TN 37040
931-648-3233

Financial Agreement, Office Policies and Patient Consent

We file your insurance as a courtesy; however, the contract is between you and your insurance company. Your co-pay is **due at time of service,** this is only an **ESTIMATE** of your out of pocket expense. To keep our fees low, we prefer to collect at time of service. If your insurance company has not paid in a timely fashion, usually within 60 days, we will request that you pay the balance and seek reimbursement from your insurance company. If your insurance company denies your claim, you are responsible for the full amount of the bill. Our office does **NOT** guarantee that your insurance company will pay and we will not enter into a dispute with your insurance company.

Our standard practice of care is to take x-rays once a year in order to diagnose treatment, should your insurance company not cover the cost of the x-ray it will be your responsibility to pay for it. Clinical Photography may be utilized on your case for the purpose of diagnosis, recordkeeping, instruction or advertising.

A service charge of 1.75% per month (21% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless a written financial agreement is made. In the event your account is turned over to an attorney/collection agency, you agree that you are responsible for not less than 35% of the attorney/collection fee.

In the case of single parent custody, separation of parents or legal guardianship by another person, the person who signs the payment policy will be responsible for payment on the account. Our office will require consent for treatment from the legal guardian prior to treatment that is more than an exam or cleaning.

A minimum of 2 business days' notice is required to reschedule an appointment, failure to keep an appointment or give appropriate notice will result in a missed appointment fee of $50. Repeat offenders will incur a fee of $50 for continuously cancelling/rescheduling appointments. Saturday appointments are at a premium, if you miss an appointment on a Saturday it will result in a fee and Saturday appointments will not be available for you in the future. If we are unable to confirm your appointment it may be removed from the schedule to allow others the opportunity to be seen. Use of cell phones or other communication devices in treatment area **will result in a $20 fee** and/or immediate termination of your appointment.

Prosthodontics (crowns, bridges, partials, dentures, veneers, bleaching trays, occlusal guards) left over 30 days are subject to a $20mth storage fee and may not be guaranteed to fit. Remakes are subject to additional lab fees, chair time and radiographs may have to be taken to verify fit. All which may result in an out of pocket expense due by the patient.

I authorize the use of anesthetic agents and am fully aware that using anesthetic agents involves certain risk, including but not limited to; redness and swelling of tissues, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness and/or lack of coordination.

Please list authorized persons with whom we may discuss your Protected Health Information in addition to custodial parents and legal guardians. (You may leave this blank if you choose to not list anyone we can discuss your PHI with)
1.____ 2.____

I HAVE RECEIVED A COPY OF THE HIPAA AGREEMENT FROM ST. BETHLEHEM DENTAL CARE AND I HAVE READ THE ABOVE CONDITIONS AND AGREE TO ITS CONTENT.

Signature of patient, parent/guardian and Date____

Printed Name of responsible party and relationship____