FRICK & JONES, P.A.
practice limited to periodontics

We are committed to providing you with the best possible care and are please to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please feel free to ask about our fees, financial policy and/or your responsibility.

Confirming your appointment: Our by appointment only schedule books heavily in advance. Confirming whether or not you will be attending an appointment reserved for you based on your specific treatment is important. We will call you two days before your scheduled appointment. Please confirm whether or not you will be attending the appointment. In the event you are late for an appointment, notifying us is appreciated so that we may determine if your appointment will need to be cancelled and/or rescheduled. We regret that we cannot continue to accommodate those who repeatedly fail or cancel appointments. Repeated failed/missed appointments will incur a broken appointment fee or dismissal from the practice. Letting us know of your change in schedule allows us to accommodate patients with immediate needs and assures adequate time for your care. **Thank you for your respect of our time and other patient's time.**

Please provide at least two daytime phone numbers at which you may be reached and an email address:
Home Phone:_____Cell:_____Work:_____
Other (please specify):_____ Email Address:_____

If you have dental insurance: Frick & Jones, PA files your insurance as a courtesy service since your insurance policy is a contract between you and your insurance company. Though we verify your benefits with your insurance company on your behalf, any coverage/payment information obtained (including pretreatment estimates) are not a guarantee of coverage or payment. Prior to any basic or major treatment, we will give you an in-office estimate based on what we know about your coverage for treatment. This will also be submitted to your insurance company for approval which will better determine your out-of-pocket expense due on the day of the appointment. By asking Frick & Jones, PA to file insurance on your behalf, you are in agreement to paying the full amount regardless of what insurance agrees or disagrees to pay after treatment, understanding that knowledge of all benefits is your responsibility as an insurance policy holder.

Treatment, billing & collections: Payment for your estimated out-of-pocket expense will be due on the day of service. We gladly accept cash, personal check, VISA, MasterCard, Discover and American Express. Checks cannot be held. Arrangements can be made prior to treatment to pay the estimated out-of-pocket expense in three payments, in the office. Though we welcome patients to build non-refundable credits on their accounts for future treatment, financing is otherwise only offered through CareCredit, which offers 6 and 12 months interest deferred (0% if paid in full within the promotional period) payment plans in the amount of $300.00 or more. Services determined by your insurance company as not being covered by your policy after treatment will be billed. We will send you a maximum of three statements

Consent for services: I hereby authorize doctor (or designated staff) to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by Frick & Jones, PA to make a thorough diagnosis of my/dependent's dental needs. I also consent to the use of x-rays and/or intraoral photos taken of me for staff education, patient education, and clinical studies by Frick & Jones, PA. NO IDENTIFYING INFORMATION WILL BE USED.

I understand that the use of anesthetics and sedatives may be necessary and with their use embodies certain risks. I am aware that by my request, I am entitled to a complete recital of potential complications. I understand that as a condition of my treatment by this office, financial arrangements must be made in advance. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services.

Patient rights/privacy practices: You have the right to look at or get copies of your health information, with limited exceptions. I grant my permission to you or your assignee to telephone me at home, by cell phone or at my work to discuss matters related to this form and all aspects of my treatment and financial planning. I have read the above conditions of treatment and payment and agree to their content. You have the right to read the Notice of Privacy (HIPPA) which provides a description of office treatment, payment activities and healthcare operations, of the uses and disclosures we may make to your protected health information, and other important matters about your protected health information. We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Patient Signature: _____Date: _____

Responsible Party Signature: _____Relationship to Patient: _____