We welcome and value you as part of our dental practice! The following are internal policies set in place by Baus Family Dental. Your signature is required at the bottom of the form in order to be seen by any of Baus Dental’s providers. Our practice accepts cash, check, VISA, MC, Discover, AMEX, Care Credit, & debit cards. Please do not hesitate to ask if you have any questions.

***Insurance Filing:*** As a courtesy, we will bill your insurance company for charges incurred at our clinic. Please remember your dental insurance is a contract between you and your insurance company. If your insurance deems a service to be not covered by your insurance plan, you will be responsible for the balance of this service and expressly agree to pay for such non-covered services: ***WE accept ALL insurances. Today's dental plans are designed to assist patients with dental treatment. It is important to remember that necessary services are not necessarily covered. Our goal as your dental care provider is to make sure you have healthy teeth long after you change dental plans. It is your employer who chooses your benefits and how they are paid by the insurance company.***

***I understand that dentistry is not an exact science so my treatment may need to be altered at the time of the appointment. I will still need to pay my portion of the visit if different from the original estimate. If the final payment from the insurance carrier is less than the estimated amount, I will assume financial responsibility for the entire balance. The estimated amount due does not take into account insurance deductibles or change in the payment allowance as delineated by your contract at the time of insurance payment. Therefore it will be your responsibility to cover the difference in accordance with your benefit plan guidelines.***

**Please initial the scenario that describes your financial/insurance situation:**

\_\_\_\_\_\_\_ I do not have dental insurance. I am responsible to pay my bill in full at each visit. The practice’s personnel will give me information on outside financing, such as Care Credit, if I request it.

\_\_\_\_\_\_\_ I understand the practice does participate with my dental benefit plan. I am required to pay my estimated portion of the dental fee at each visit for the treatment rendered that day. The amount I will be required to pay is an estimate and will be explained to me prior to my appointment. I also understand that my insurance is an agreement between the insurance company and me; therefore if the practice does not receive payment from my company in 90 days, the insurance balance for my account will be transferred to me personally.

\_\_\_\_\_\_ I understand the practice does ***not*** participate with my dental benefit plan; but will wait for the assignment of benefits as a courtesy

to me. I understand I am responsible for my account regardless of my insurance status. I also understand that my insurance is an agreement between the insurance company and me; therefore if the practice does not receive payment from my company in 90 days, the insurance balance for my account will be transferred to me personally.

***Collection Fee:*** If your account balance is past due over 60 days your account will be charged an 18% finance charge in accordance with

Wisconsin law for the portion of your balance that is overdue. This is subject to the discretion of the practice administrator.

***Non-sufficient funds:*** A $35.00 charge will be added for any non-sufficient funds notice received from the bank.

***Co-payments, Co-insurance, & Non-insurance covered procedures:*** Payment for all services is due on the date of service.

***Cancellation policy:*** I must respect the practice’s schedule and will give 24 hours notice if I need to change my appointment time, otherwise, I may be assessed a $50 fee for the loss of appointment time.

**I have read, agree to, and understand the statements listed above. I have received a copy of this document for my records.**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Signature Today’s Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: **PLEASE PRINT** Date of Birth

***Minor children at the office for treatment without your presence; please read and initial below:***

\_\_\_\_\_\_ I give my permission to treat my minor child/children in my absence, whether I drop them off for treatment or another adult brings them to the office for treatment. I will give my child a check or credit card information to fulfill the amount due for their treatment.

***Adult child (over 18) and will continue to be financially responsible for their treatment, fill in child’s name and initial below:***

\_\_\_\_\_\_ I will continue to be financially responsible for (child’s name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If I have insurance I will provide my

 insurance company with the necessary documentation that they are a full time student. Most insurances cover adult children until 26.

This consent was signed by;

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_until revoked**

Signature of patient or legal representative Date

**Baus Family Dentistry abides by HIPAA guidelines as set by the federal government.**

***HIPAA-Patient Consent***

**The patient understands that:**

* Reminders of upcoming scheduled appointments may be left on answering machines, voicemail, emails, or via texts with a family member, and/or a postcard may be sent to your household.
* We can send radiographs with minimal amount of information necessary via unencrypted email on your behalf when referring you to another provider.
* We can fax prescriptions to your pharmacy on your behalf.
* Protected health information may be disclosed or used for treatment, payment, or dental care options.
* Baus Family Dentistry (Michael S. Baus D.D.S., S.C.) has a “Notice of Privacy Practices” and the patient has the opportunity to review this notice.
* The patient may revoke this consent in writing at any time.

 Please sign that you acknowledge our HIPAA policies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \*\*Parents may not sign for children over the age of 18.

**Radiographs/Intraoral photos**

(Please initial in box for acknowledgement)

Radiographs & close-up mouth photos can be used by Baus Family Dental for educational and advertising uses. \*\*Photos with eyes will NOT be used unless verbally discussed & given signed release by Doctor, but mouth photos can be.

**Composite Fillings:**

 (Please initial in box for acknowledgement)

At Baus Family Dental, we feel composite resin (white) fillings are a superior restoration. If you do insist on placement of an amalgam (silver) restoration, please advise the Doctors at time of treatment.

**Authorization for disclosure of dental records**

I am authorizing disclosure of any of my medical records to the following people.

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Relationship)

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name) (Relationship)