

HIPAA & FINANCIAL POLICY 2024

GALLERIA WEST DENTAL, SC

Private Pay, In-House Plan or Discount Plans are collected at time of service.

Insured:

Dental claims are filed electronically & patient responsibility amounts are due **in full** upon receipt of insurance payment statements. If not received, additionally you will receive a statement from Galleria West Dental.

Payment Plans are not available.

Should you require a payment plan: pay with Care Credit for either a 6 or 12 monthly payment. (Go online to get qualified prior to service rendered). Otherwise, we will accept **pre - payments** prior to service rendered, so that at the end of treatment your balance is paid in full and you will then received a savings for payment in full.

We accept payment by phone with no fee at 262-754-2727 during normal business hours. (Mon-Tues-Thurs) 8-5:30PM Or online at www.BrightSmiles.net, anytime of day or night.

Cards accepted: MC, Visa, Discover, AM-EX (Debit & Credit) & Care Credit along with HSA or Flex Benefit Cards.

Insurance Disclosure:

Typical coverage is 100% Preventative / 80% Restorative/ 50% Major

***Not including Deductible & Plan Maximum**

Our goal is to assist you with questions regarding your dental benefits.

Please check with your insurance regarding benefits & eligibility to clarify that Dr. May is in your network and accepts the particular plan that you signed up with. Reminder: Employers often change insurance & benefits in the new year.

Due to the complexity of hundreds of plans, we are unable to guarantee exact out of pocket expenses. Knowledge of plan limit & maximum is your responsibility; however, we will assist in estimates based on typical coverage if requested.

Past Due Account Disclosure:

60 Days Past Due-We reserve the right to charge account balances that are 60 days past due, an annual percentage rate of 18%. **90 Days Past Due accounts - will be reviewed for referral to Advantage Collection Agency, promptly!**

Privacy Practice: You may request a copy of our Privacy Practices. I consent and authorize the doctors of GWFD to share info (Insurance/X-rays/Referrals) with Specialty Providers & to perform any treatment discussed regarding your dental care and your insurance. I understand treatment can change mid- course and alter the original treatment along with estimated cost.

I give permission to my Spouse/Partner and when patient is a minor; either parent the ability to schedule appointments, make payments and discuss account balances or treatment needed. When adult children reach the age of 18, please advise when you would like to have them become responsible for their own account as they remain on yours until we are notified.

HIPAA AND FINANCIAL POLICY OF GALLERIA WEST DENTAL 2024

I fully understand this financial policy and will make payment in full at time of service or upon receipt of statement or insurance notification and grant permission for shared information as disclosed below. I agree to the HIPAA privacy practice, privacy authorization and I do consent to these practices.

Print your full name: _____

I allow the following to make appointments, pay bills & discuss my/our account on my behalf:

Spouse /Partner

Parent

Children under 18

Signature: _____

Signed On: _____

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