Financial Office Policy for Renee Corbitt, D.D.S.

Welcome to the office of Dr. Renee Corbitt. This document represents our financial policy. If you have any questions or concerns, please do not hesitate to ask.

You are responsible for all charges to your account whether or not your insurance company makes payment. Your insurance policy is a contract between you and your insurance company. Our relationship is with you, not your insurance company. We cannot guarantee payment of your claim. Not all services are a covered benefit in all contracts. Even with a predetermination, payment is not guaranteed. Your insurance company makes that determination when the actual claim is filed.
_____*initial please*

At the time that services are rendered, you are responsible for any unpaid deductible that is due and any co-payments due for that particular service. The total balance of your account is to be paid within 60 days of service date. If your insurance company has not paid by this time, it is your responsibility to pay the account and refile your insurance.

We reserve this time for you. Appointments are confirmed by email and/or text only. If you are unable to keep your appointment, we ask that you give at least *2 business days notice*. If such notice is not given, then you are subject to a charge of not less than $50 for each missed appointment. *We do charge for missed, forgotten and late appointment cancellations, please call the office as soon as you know you need to change your appointment.*
_____initial please

We accept cash, check, MasterCard, Visa, Discover, American Express and debit cards.

We are not able to offer in-office payment plans. We use a third party provider, Care Credit for payment plans. A credit application is submitted to them for approval. You can apply online at *CareCredit.com*.

Accounts that become 60 days old are subject to a monthly interest charge of 1.5%. This is an annual rate of 18%. Accounts that remain unpaid after 90 days may be sent to our collections service. This may appear on your credit report. I agree to pay all additional charges and legal fees to recover any outstanding balance of my account.
_____initial please

All checks that are returned by the bank are subject to a $25 charge. Checks that remain unpaid can be referred to the Tarrant County District Attorney's office for prosecution.

continued on next page……

By signing this agreement, I acknowledge that I have read this agreement and agree to abide by these terms.

_____ _____

Signature **Date**

Assignment of Benefits and Medical Release

I have requested that Dr. Renee Corbitt file my insurance claims on my behalf for services rendered to me/or my dependents. I authorize my insurance company to make payment directly to Dr. Renee Corbitt. I understand that I am financially responsible for *any* balance on my account. I authorize Dr. Corbitt to release any medical information that is requested for my claim to be paid.

_____ _____

Signature **Date**

Acknowledgement of receipt of notice of privacy practices

You may refuse to sign this acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____

Signature

_____ _____

Please print name self, parent or guardian Date

For office use only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communication barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining acknowledgement
____ Other (please specify)