Dr. Curtis G. Dean, DDS 2575 Evelyn Byrd Ave**,** Harrisonburg, VA 22801 540-432-2315

Request a Copy

Consents and Policies

We appreciate you allowing us to provide dental care for you. Because we value our relationship with you and we believe that the best relationships are based on understanding and communication, we offer these explanations of our office policies.

Consent for Dental Treatment: I request and authorize Dr. Curtis G. Dean and his staff to provide dental services including, but not limited to, dental exam, diagnostic radiographs, cleaning, and necessary treatment recommendations.

Dental Insurance Policy: Dental insurance is a very positive benefit for many individuals and families and plays a major role in helping individuals obtain good dental care. The primary objective of all types of dental insurance is to aid you by partially paying for certain dental care expenses

Dean Family Dental is an out of network provider, we do NOT directly participate with insurance plans/companies. As a courtesy to our patients we will file all dental insurances, but we are a non-participating provider. It is important to us to be able to offer individualized treatment based on your specific dental needs, unrestricted by the limitations that many dental insurance plans impose.

Please remember, your insurance contract is between you and your insurance company. Our responsibility is to provide you with individualized care based upon your dental needs. We will file all insurance claims for procedures completed, send all requested information, follow-up on all claims pending, and send appeals as needed. We will make every effort to assist you in maximizing your dental benefits. Regardless of your insurance coverage, you have the final and full responsibility of all costs incurred at our office.

_____ **Assignment of Benefits:** by initialing this line, I authorize my insurance company to pay the dentist all insurance benefits rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am responsible for all charges not paid for by insurance.

Financial Policy: This office depends upon reimbursement from patients for the costs occurred in their care. Financial responsibility on the part of each patient must be determined before treatment. I understand that Dean Family Dental does NOT directly participate with any insurance plans/companies. I understand that I am responsible for all balances not paid by my insurance plan.

All account balances are to be paid at the time of services or immediately following the processed insurance claim. If the account is not paid on within ninety (90) days of service, the patient will be charged an additional $35 late fee, monthly until account balance is paid. I understand that if my account is outstanding after ninety (90) days of service without prior arrangements that my account may be referred to a collection agency or an attorney for collections. I agree to pay all costs of collections, including but not limited to monthly late charges, collections fees, attorney fees, and all court filing and court costs.

It is our expectation that all accounts will be paid off within 90 days of service.

Missed Appointment Fee: We understand that unforeseeable circumstances occur and sometimes require missing an appointment. However, after a reoccurrence of missed or cancelled appointments without a 24-hour notice, you will be charged a $50 missed appointment fee.

Late Policy: Please understand, for a typical 1-hour appointment, tardiness greater than 15 minutes can greatly impact the quality care we are able to provide you. Therefore, if you will be greater than 15 minutes late please contact our office to see if you need to be rescheduled to receive the best quality care. We will make every effort to see you as promptly as possible.

Returned Check Fee: If a check is returned to us, unable to cash, there will be a $30 return check fee.

Billing: To increase efficiency and minimize waste, we do NOT send paper statements in the mail. If we are unsure of what your balance will be following your appointment, we will file your insurance claim and call (or E-Invoice or text if preferred) you with your account balance after your insurance claim processes and pays. The estimation of benefits you receive in the mail from your insurance company should match the receipt you leave with on the date of service. Paper statements are only mailed at the request of a patient.

Credit Card on File (optional): Our office can keep a credit card securely on file for the convenience of paying the remaining balance on an account. When kept on file we can only visualize the last 4 digits of the card. If a balance is processed on the credit card, we will mail or email a receipt.

Payment Options: We make every effort to work with our patients to accommodate financial needs. We accept all major credit cards, check, cash, and Care Credit®. We are willing to work with patients to extend payments up to 6 months under our Extended Payment Agreement (requirements: credit card on file & set date to automatically process payment), please ask us for more detail. For patients who may need to extend payments greater than 6 months we accept Care Credit® at 0% interest for 12 months if balance is greater than $500.

Text Message Confirmation: Due to patient confidentiality, we no longer mail postcard appointment reminders. If a cell phone is in our system you will receive a text message one (1) month prior to the appointment- as a friendly reminder; one (1) week prior to your appointment to text back and confirm, and one (1) day prior as a friendly reminder. Please understand these are meant to be friendly reminders. If we do not have a cell phone number or you prefer not to get text message reminders, please let us know and we will call you 24 hours prior to your appointment.
You are welcome to text our landline number to communicate with us, if you prefer.

HIPPA Acknowledgement: I understand that I may inspect or request a copy of the protected health information described by Dean Family Dental's authorization. I understand that no piece of protected health information will be released to another individual or office unless signed consent is signed by the patient. Please request a copy of our HIPPA Disclosure Form to read and/or keep. I understand that this will serve as my electronic signature for the HIPPA Disclosure Form.

_____ **Please initial to indicate, this will serve as my signature for understanding the HIPPA Disclosure Form. Please request a copy.**

Please update an Emergency Contact

Dean Family Dental

Name Phone Number

Please list any dependents you are responsible for:

_____

_____

_____

By signing I am consenting to treatment and understanding of the follow policies listed above.

_____ _____

Signature **Date**

Request a COPY: Dean Family Dental Consents and Policies