OFFICE GUIDELINES

Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Office Guidelines. **We require you to read and sign this prior to any further treatment.** All patients must complete our information and insurance form before seeing the doctor.

1. Full payment is due at the time of service (unless previous arrangements have been made).
2. We accept cash, checks, or Visa//MasterCard.
3. We offer an extended payment plan with prior credit approval.
4. Although we hope that this never happens but should your account have to go to collections you will be fully liable for all collection costs, including court costs and attorney fees.

Regarding Insurance

We may accept assignment of your insurance benefits in the event of active therapy. However, we do require you to pay the percent that your insurance company doesn't pay at the time of service. We can do a pre-estimate with the insurance to know what they will pay. The balance is your responsibility whether your insurance company pays or not. **Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.** If your insurance company has not paid your account in full within 60 days, the balance will automatically be your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered and not considered reasonable and necessary under your insurance policy.

Maintenance Patients with Insurance

Payment is due in full at the time of service; we will file your insurance claim and have them reimburse you.

Work/School Appointments

It is impossible for Dr. Braun to see all of his patients outside of usual working/school (9-5) hours. Some appointments will have to be scheduled during these hours.

Minor Patients

The adult accompanying a minor and the parent (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at the time of service.

Missed Appointments

Unless cancelled/rescheduled at least **48 hours in advance**, our policy is to charge for missed appointments at the rate of **$150.00** per scheduled hour. If you are **scheduled for surgery we need five business days notice**. Pre payment for sedation is due 1 week prior to any surgery. This is non-refundable if cancelled with less than 5 business days notice. Please help us serve you better by keeping scheduled appointments. Please let us know if you have any questions or concerns.

I have read, understand and agree to these Office Guidelines.

X____Date________________________

Signature of Patient (if 18 years or older), or Guardian

HIPAA PRIVACY FORM

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You may refuse to sign this acknowledgement****

I, ____________________________, have received a copy OR read the explanation of this office's Notice of Privacy Practices.

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{Signature of Patient and/or Guardian} {Date}__________________

{Relationship to Patient} Self or Other: ______________________

I, __________________________, acknowledge and allow Thomas B. Braun, DDS, MS, PC- Thomas B. Braun, D.D.S. to share my information with the following people besides those already stated within the Notice of Privacy Practices.

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____

[ ] Child(ren) ____

[ ] Other ____

[ ] No information is to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

The best time to reach me personally is (day) ____________________ between (time) ________

Please call [ ] my home phone [ ] my work number [ ] my cell number

____________________ ________________ __________________

If unable to reach me:

[ ] you may leave a detailed message [ ] please leave me a message asking for a return call OR

[ ] you may e-mail me at ____

Signed: ____ Date: ____/____/_______

Witness: ____ Date: ____/____/_______