Dr. Theresa C. Hauck P.C.

FINANCIAL PRIVACY/CONSENT POLICY

Thank you for choosing us as your dental provider. Please read this form carefully. You are required to read and sign prior to any treatment.

INSURANCE

It is the patient's responsibility to understand their insurance coverage. We suggest that you call your insurance company prior to your visit so that you better understand your coverage and limits to your benefits. We ask that you bring your current insurance card to each visit, as addresses may change. **We cannot bill your insurance company unless you give us your current insurance information. If you do not have your insurance card, you will be responsible for payment at the time of service. We bill your insurance company one time as a courtesy to you.** If your insurance company has not paid within 60 days, the balance will become your responsibility and be due in full. It is the patient's responsibility to make sure the insurance company pays their claims. We will not resubmit your claim unless requested by you specifically. We will not falsify records, as this is against the law.

COLLEGE STUDENTS

If you are on your parent's insurance as a full time student, every insurance company requires that you fill out a student verification form each semester or your claim will not be paid. It is your responsibility to make sure this is done.

MINORS/PARENTS/GUARDIANS

Parents/Guardians are responsible for the payment of the minor's account. We do not get involved in divorce/custody payment arrangements. In all cases the parent/guardian that accompanies the minor assumes all financial responsibility for the minor's account.

DENTAL RECORDS

If at any time you wish to request your dental records for any reason including transferring to another doctor, there is a reasonable fee of $20 to $35 based on the amount of records in your file. Also, a signed record release is necessary before records will be released.

APPOINTMENTS

You as a patient may be discharged from our practice for non-compliance of appointments. This includes excessive rescheduling of appointments and/or not showing for appointments. We reserve the right to charge if you do not show for an appointment.

With my consent, Dr. Hauck and her staff may call my home or other designated location and leave a message on voicemail or in person, in reference to any items concerning their treatment.

I have read and agree to the policies stated in this document.

Patient Signature Date

Address City State Zip Cell Phone Number