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Financial Policy

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This is an agreement between Guy M. Hanson DDS, PA, a Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Guy M. Hanson, DDS, PA.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month. A rebilling fee of \$1 may be imposed on each statement.

Payment options if you have no insurance:

1. Payment in full by __cash, __check, or __credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance in three weeks.
3. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution.

Payment options if you have insurance:

4. A payment of your deductible and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card.
5. You choose to pay all of your treatment by __cash, __check, or __credit card. We will request your insurance carrier send their payment directly to you.
6. On extensive treatment (crowns or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date. (Normally two-three weeks later.)

Emergency patient:

7. If you are a non-established emergency patient, you are required to pay in full at the time of the services.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the due date listed on the statement.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. As a courtesy, we may offer assistance with preauthorization. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Patient's Initials

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and three quarters percent (1.75%) per month or an **ANNUAL PERCENTAGE RATE** of twenty one (21%) percent. The finance charge on your account is computed by applying the periodic rate (1.75%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed sixty (60) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is \$.50.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau. We reserve the right to not offer credit.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Returned checks: There is a fee (currently \$26) for any checks returned by the bank.

Missed appointment fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a \$52 fee per each thirty (30) minutes of scheduled time. This fee must be paid before a new appointment is scheduled.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to an attorney, you agree to pay all attorney's fees which we incur plus all court costs.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, both parties remain liable for services rendered prior to the divorce or separation. In the case of services are rendered to a minor child, Idaho Law makes both parents responsible for treatment costs for their minor child/children. We can collect from either or both parents for payment of those costs. If the divorce decree requires one spouse or parent to pay all or part of the treatment costs, we are not legally bound by such decree and can continue to look either at both spouses or both parents in the case of treatment provided to minor children, for payment. It is the other spouse/parent's responsibility to collect from the other spouse/parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible party
(if not the patient): _____

Signature: _____ Date _____