



Insurance Policy

We are happy to file the necessary form to see that you receive the full benefits of your coverage. However, insurance companies only pay the assigned percentages on what they feel like service should cost not what we charge. Due to this, you may be charged the difference between our fee and what your insurance will pay. Claims are paid according to usual, customary, and reasonable fee which varies per insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Scott Family Dentistry is in no way involved in this contract.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay.

Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers
3. Conduct normal healthcare operations such as quality assessments and physician certifications. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed.

Cancellation Policy

In order to see or treat our patients to the best of our ability we now have a policy in effect for cancellations. You must give our office 24 hour notice to change or cancel an appointment.

Our staff strives to give you the best service possible. It is important that our patients understand our office policies and work with us to exceed our expectations.

Patient Name: _____ Date: _____