Metro Dentalcare Minnetonka Financial and Insurance Policy

Your estimated patient portion is due date of service. If you have accumulated a balance, we are unable to see you until the balance is paid off. Insurance always has the last say in any claims so if you have questions on why they did not pay for something fully then please reach out to your insurance. We provide a treatment plan with an estimated portion as a courtesy, and we send out a pre auth to your insurance. However, it is ultimately your responsibility to know your insurance plan and coverage.

We check your insurance as a courtesy, but we do work with thousands of different plans and coverages daily. When your insurance changes it is your responsibility to notify us so we can better estimate your portion. We would prefer it if you called ahead with new insurance information before your appointment, but you can also come a few minutes early to provide that information.

We do not accept: Insurance through the state, Minnesota Health programs, MHCP, PMAP, U-care if the patient is under 65 years old.

We do accept most insurances through an employer. Please call if you have questions on whether your insurance is covered.

Cancellation policy: We set aside amble time for our patients to make sure you are taken care of. We value your time as much as ours, If you cancel 24 hours before your appointment, we will charge $65 (this is per person per appointment so if you are a family of 3 and cancel three appointments then a $65 charge will be added to each person's account).

Confirmation policy: We ask that you confirm your appointment through written or verbal communication at least 24 hours before your appointment. We call a week before your appointment to confirm, and you do get automatic text and email reminders. If you do not confirm through written or verbal communication 24 hours before your appointment, we will have to release that appointment to other patients.

Please sign and date below to confirm that you have read and understand our policies

Signature: Date:

_____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name of Person	**Relationship to Patient**

Signature:

_____

Date:

_____

Lifetime Whitening Program Policy

*We are offering Lifetime Whitening as an incentive to ensure optimal oral health by maintaining a 6 month continuing care cleaning frequency. This program provides you with custom fit trays and a life time supply of whitening. Enrollment cost is $215.00 for the initial appointment, trays and starter whitening packs (Valued at $409.00). At re-care appointments, you are eligible for a **FREE** whitening refill pack. (Valued at $78.00 x 2 per year- $156.00!)*

To continue the Lifetime Whitening Program and be eligible for refills you must maintain a 6 month continuing care cleaning frequency or you automatically forfeit the program. To ensure this happen we suggest scheduling re-care appointments directly after each appointment. We understand life happens and if you need to reschedule we will work with you to get you re-scheduled, however, if the appointment exceeds 10 months since your last appointment a $75.00 re-enrollment fee applies.

Please sign and date to indicate you have read and understand the policy.

Signature: _____ *Date:* _____