Jennifer Oliveira, D.D.S. - Financial Policy

Thank you for choosing us as your dental care provider. It is very important to us to provide you with the very best of care in a comfortable environment. We also strive to ensure that you clearly understand our financial policy and treatment needs. We will do our best to explain the fees associated with your needs as well as insurance benefits. For unaccompanied minors, we ask that financial arrangements be made prior to the day of their appointment.

Fees for services are due in full on the day of services. We accept cash, checks, Visa, MasterCard, Discover, and American Express. We also offer extended payment plan options upon credit approval.

Insurance: We are happy to accept insurance coverage. We will verify your insurance on your behalf and determine your policy's estimated coverage for recommended treatment. Please understand that all insurance companies only tell us what they are estimated to pay. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier. You are ultimately responsible for all fees generated by your treatment. The estimated patient copay and deductible for treatment rendered must be paid in full the day of service.

You authorize Dr. Oliveira to release any necessary information requested by your insurance carrier and authorize payment directly to Dr. Jennifer Oliveira for any benefits available under your insurance plan.

Checks: There is a $30 service fee for any checks returned by the bank.

Cancellations: Please help us serve you and our patients with the best time management by keeping your scheduled appointments. If it is necessary to reschedule an appointment, please give us 48 hours notice so that we may extend the courtesy of this time block for a patient on our waiting list. Lack of notice incurs a $50 cancellation fee.

By signing this form below you are agreeing to the statement: “I have read and understand the office appointment and financial policy.”

→**Print Name**_____

→**Signature**_____ **Date**_____

HIPPA PRIVACY ACKNOWLEDGEMENT

You May Refuse to Sign This Acknowledgment

By signing below, you are simply acknowledging that our office gave you the opportunity to read and/or take home a copy of **YOUR** privacy rights. Our office needs to make this statement available to you. Call or email for this copy if signing via email.

I, (full name), have received a copy of the “Jennifer Oliveira, D.D.S. Notice of Privacy Practices.”

→ **Print Name**_____

→ **Signature**_____ **Date**_____

If this Acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name_____

Relationship to Patient_____

For Office Program Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- O Individual refused to sign
- O Communication barriers prohibited obtaining the acknowledgment
- O An emergency situation prevented us from obtaining acknowledgment
- O Other (Please Specify)