

Kiene Dental Group, LLC Generations Dentistry and Sedation Center

Office Policies, Procedures and Patient Authorizations

Payments

Kiene Dental Group, LLC accepts payment in the forms of cash, personal/company checks, money orders, MasterCard, Visa, discover Card, and American Express.

Initials _____

Insurance

If you have insurance, we will be happy to file your insurance claim as a courtesy. However you will be responsible for your deductible and coinsurance at each visit. Our computer software makes an estimate of what your insurance will cover and estimates what will be your "out of pocket" portion. This is only an estimate and it is possible that your insurance may cover less than what is estimated. If this should happen then the remaining balance will be your responsibility to pay.

Initials _____

Interest Free Payment Options

We do offer interest free payment options through Care Credit Financing. This is a company not affiliated with Kiene Dental Group, LLC and we do not have any control over acceptance in this program. We will assist you in the application process as much as we possibly can.

Initials _____

Financial Arrangement

Financial Arrangements may be possible. They must be made in advance, before any treatment has been started. Financial arrangements are at discretion of Kiene Dental Group, LLC and will be handled on a case by case basis.

Initials _____

Full Payment Discount

For patients who do not have insurance or patients with insurance that do not require a contracted adjustment we offer a discount for payment in full with cash, check or debit card at the time of service. (No credit cards) These discounts are not applicable with the use of any other offer or coupon.

Initials _____

Finance Charge

Accounts that have had a financial arrangement made or that carry a balance from one billing month to another will incur a 5% monthly finance charge on the carry over balance.

Initials _____

Delinquent Accounts

We will consider an account delinquent when the balance goes unpaid for 90 days without a financial arrangement in place or on accounts with financial arrangements that have defaulted on the agreed upon financial arrangement. Accounts in one of the two before mentioned conditions may be turned over to an outside collections agency for handling. A patient whose account has been turned over for collections will be responsible for all collection and court costs associated with this process. Patients who have had their accounts turned over to collections will no longer be considered active in the dental practice and will only be seen on a cash basis once the balance has been taken care of with the collection agency.

Initials _____

Return Check Fee

If payment is received in the form of a check written by the patient or on behalf of the patient, it is understood that the patient's account will be charged a returned check fee in the amount of \$30.00. It is also understood that any future payments made to Kiene Dental Group, LLC will need to be in the form of cash, credit card, or money order.

Initials _____

After Hours Phone Calls/Emergency Service

Our doctors are here for our patients when needed. They are available to take after hour's calls for all dental emergencies. Our normal office hours at Kiene Dental Group, LLC are Mondays and Wednesdays 7:30am to 6pm, Tuesdays and Thursdays 7:30am to 5pm, and Friday 8am to 3 pm. If you have an after hour's emergency please call the office's main line and the recording will give you directions to leave a message for the doctor on call, who will return your call as soon as possible. If the doctors come into the office to see you after hours there may be a \$170.00 after hour's fee applied to the visit.

Initials _____

Missed Appointments

It is understood that Kiene Dental Group, LLC, may but is not required to, confirm my upcoming appointment date and time. Such a reminder may be in the form of a phone call, post card, an e-mail, text message, or any combination of the before mentioned. The patient understands this is a courtesy and that they are ultimately responsible to keep their dental appointments. If an appointment is missed without a 24 hour notice, it is understood that Kiene Dental Group, LLC may charge a \$25.00 missed appointment fee. Please note that insurance will not reimburse this and it is the responsibility of the patient to keep all scheduled appointments.

Initials _____

Prime Time Appointments

In our practice we have found that our late evening (4pm to 6pm) appointments and our early morning (7:30am) appointments are highly sought after by our patients. If you have one of these "Prime Time" appointments and need to reschedule or cancel it is very important that you give us at least a 24 hour notice. If we do not receive at least a 24 hour notice you may be subject to the above missed appointment policy, and if you miss a "Prime Time" appointment twice without a 24 hour notice to the practice, we will no longer be able to guarantee one of our "Prime Time" appointments for you.

Initials _____

Late Arrival for Appointments

We understand busy schedules and that at times things come up that will put you into a time crunch. However, if you arrive **15 minutes** late for your scheduled appointment you may be asked to reschedule. This is done out of respect for our other patients that have appointments scheduled. We would also ask that you call ahead and let us know you are running late, and we will do all that we can to still accommodate you when our schedule permits.

Initials _____

Authorization for Treatment

I the patient here by give my authorization to the dentists and team members of Kiene Dental Group, LLC to render dental treatment to me that they judge to be beneficial to my oral and overall health. In giving this authorization it is understood that my dental condition will be explained to me and options for the treatment of said dental condition will be explained with pros and cons of each treatment option.

It is further understood that I have the right to refuse any treatment option presented. However, with refusal of treatment, it is also understood that the dentists at Kiene Dental Group, LLC have the option to refuse future treatment and even dismiss me from the practice when such refusal of treatment is seen as detrimental to my future dental health, or compromises the professional ethics of the dentist.

Initials _____

**I HAVE READ AND UNDERSTAND THE ABOVE POLICIES AND PROCEDURES
AND GIVE THE ABOVE AUTHORIZATION FOR TREATMENT TO:
KIENE DENTAL GROUP, LLC**

Print Patient's Name: _____

Patient Signature

Date

If Patient is a minor (under 18) or under the care of a care giver:

Print Responsible Party's Name: _____

Relationship to Patient: _____

Responsible Party's Signature

Date

I HAVE BEEN GIVEN THE OPPORTUNITY TO READ AND REVIEW, AND BEEN GIVEN A WRITTEN COPY, IF REQUESTED BY ME, OF THE NOTICE OF PRIVACY PRACTICES FOLLOWED BY:

KIENE DENTAL GROUP, LLC

I HAVE ALSO GIVEN MY PERMISSION FOR MY MEDICAL AND PERSONAL INFORMATION TO BE SHARED WITH THE FOLLOWING INDIVIDUALS ON MY BEHALF.

Person's Name Relationship to Patient

Person's Name Relationship to Patient

Person's Name Relationship to Patient

(If no individuals are listed above, we will only share your medical/personal information when pertinent with other Dental or Medical Professionals with whom we are referring care to if needed.)

Patient/Responsible Party's Signature Date

Patient Name: _____

Patient Name: _____