UNIVERSITY DENTAL GROUP
PREVENTIVE • RESTORATIVE • COSMETIC
Katherine Spellman, D.D.S. • Lauren Patrick, D.D.S.
4626 University Avenue • Des Moines, Iowa 50311
515•277•3766
www.universitydentalgrouppc.com

PAYMENT POLICY FOR DENTAL CARE

Dental Insurance Patients

- Please be aware that your account is your responsibility, not that of the insurance company, even though you may have dental insurance.
- Deductibles and estimated co-payments are due at the time of service. If there is a remaining balance due after receipt of the insurance payment we will contact you.
- Estimates are based on information obtained from your insurance company.
- We are happy to contact your insurance company to obtain benefit information.
- As a courtesy to you, we can provide a written treatment plan for any treatment recommended by the doctor. The treatment plan provided is an estimate only, not a guarantee of benefits or payments. It is our duty to recommend the most appropriate treatment for you, regardless of whether or not insurance benefits are available.

No Insurance Coverage

- Payment in full is due at the time services are rendered.
- As a courtesy to you, we can provide a written treatment plan for any treatment recommended by the doctor.
- For the convenience, our office accepts Visa, MasterCard, Discover, CareCredit, Cash and Green State Credit Union.

POS Reorder # 2217429
8/22 (Rev.)

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of University Dental Group. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

University Dental Group reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐ **YES**	☐ **NO**
PARTNER / SPOUSE ONLY	☐ **YES**	☐ **NO**
OTHER (***PLEASE SPECIFY***): _____	☐ **YES**	☐ **NO**

_____

_____ _____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

PROVIDED PRIOR TO TREATMENT?		YES		NO	
DATE PROVIDED:					
REASON FOR DENIAL:		NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.			
		WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.			
		UNABLE TO SIGN.			
		REASON NOT GIVEN.			
		OTHER (EXPLAIN):			

Please continue on back →

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FINANCIAL POLICY

At University Dental Group, we don't want anything to stand between you and an amazing smile. We offer a variety of payment options to meet the needs of individuals and families. We will work with you to find a payment method that fits your budget and lets you receive the quality care you deserve.

Due to constantly changing insurance regulations, benefits and deductibles, we are only able to *approximate* your insurance balance.

Full payment of the patient's portion is expected at the time of service unless other financial arrangements have been made.

For your convenience, we offer the following payment options:

CASH	VISA
CARECREDIT	DISCOVER
MASTERCARD	

If there are some extenuating circumstances that we are not aware of, please call the office to discuss payment arrangements, (515) 277-3766. It is a privilege to serve you.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection of your unpaid balance.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims; for additional specialist consultation; or in the event I request my records to be transferred to another dental office.

Patient Signature _____ Date _____

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