Hoybjerg Family Orthodontics Initial Exam Consent

Thank you for choosing Hoybjerg Family Orthodontics as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our financial policy.

We accept payments in CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, and CARE CREDIT.

- When mailing a payment, the payment is due to the following office location:

  Hoybjerg Family Orthodontics
  9550 Micron Ave. Suite A
  Sacramento, CA 95827

- Prompt payment is essential. We must receive your payment on or before the due date.
- Payment options are not based on treatment time. In some cases, contracts may extend past treatment time. Payments on contracts are to continue until payment in full.
- Contracts are not subject to penalties if paid in full early.

CONTRACT AGREEMENT

- As a courtesy we offer a 10 day grace period from your due date. After the 10 days, an automatic $30 late fee is applied.
- If a payment is returned unpaid there will be a $25 returned check fee. This fee is due immediately and if it is not paid within 10 days, is subject to a $30 late fee.
- Contracts are required to be set up on automatic payment to avoid billing charges of $10 per month with a maximum of $240 that is added to your contract.
- We reserve the right to charge a 20% finance charge.
- Automatic payments are not re-submitted without authorization.
- If any changes need to be made to your automatic payment, the financial department requests a minimum of 5 business days prior to your payment withdraw.
- Your account and account information must be kept current at all times. Should you change your address, telephone number or job, please notify us so we can keep your information current. This will eliminate any disruption on your contract. If you need to make any changes on your contract or payment please contact us at **(800)252-1223 ext 1105 or 1313.**
- Billing statements are only sent out on past due accounts at the beginning of each month.

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CANCELLATION POLICY

- A 24 hour cancellation notice is appreciated. If the appointment is not canceled or re-scheduled within 24 hours prior to your appointment, there is a no-show fee of $25 for that missed appointment. Please help us serve you better by keeping scheduled appointments.

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OFFICE POLICY ON PAST DUE ACCOUNTS

- Accounts are monitored by our financial department and at any time we reserve the right to cancel an appointment if an account should become more than 60 days past due.
- Our financial treatment policy will extend progressive treatment up to 60 days past due. Once the account is defaulted by 90 days the discontinuation of services will be started.

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MINORS

- The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.
- For unaccompanied minors, current balance is due at time of check in. Non-emergency appointments will be denied if balance unpaid.

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INSURANCE AGREEMENT

- Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers routinely stall, deny, and reduce payments. To that end, our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement, while reducing the time in which they pay.
- We will gladly bill your insurance as a courtesy; however, we do not submit automatic disputes if for any reason your claim is denied.
- You are responsible for getting proper referral in advance of your appointment.
- Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due as per your contracted agreement. In the event your policy will terminate, your co-pays will be increased to our usual and customary rates.
- If your insurance changes or terminates we request that you notify our insurance department, so we can promptly update your account and discuss any possible changes.

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AUTHORIZATION FOR SIGNATURE ON FILE

Release of information/Financial Responsibility/Assignment of Benefit: I hereby authorize the office of Hoybjerg Family Orthodontics, to affix my name to any all claims or documents as related to any and all health benefits due to me and my dependents through my employment. I hereby authorize payment of orthodontic benefits otherwise payable to me, directly to Hoybjerg Family Orthodontics. I have read, understand and agree to the terms and conditions of this document. To the extent permitted under applicable law, I authorize release of any information related to insurance claims.

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CONSENT FOR TREATMENT

The initial examination visit may also incorporate the taking of initial records (photographs, radiographs, and study models) as needed. The records are often required to establish a comprehensive treatment plan.

PATIENT NAME	SIGNATURE OF RESPONSIBLE PARTY	DATE