Favour Dental

Dr. Troy Bonin

5403 FM 1488 Suite A7
Magnolia, Texas 77354
281.259.6717

Assignment of Benefits and Financial Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

►Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

►We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

►Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

►Our office does not guarantee that your insurance company will pay for treatment you receive from our practice/ We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

►Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

Missed & Cancellations:

We may charge for all missed appointments **without** a 48 business hour notice given to the office. Treatment/Production appointment(s) may occur rates of $50.00 for the first hour and $25.00 per every 30 mins thereafter per provider/per appointment. A ***forty-eight (48) business hours*** notice is required to avoid all fees.

CANCELLATIONS CAN NOT BE ACCEPTED VIA EMAIL, TEXT, OR VOICEMAIL.
WE ASK TO CONTACT OUR STAFF PERSONALLY TO AVOID FEES.

Charges & Payment:

All services rendered will be the responsibility of the patient. Payment(s) for services performed will be collected upon checking in, including any past due, or non-covered benefits by the insurance.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO DR. BONIN, SMILES LLC. I HAVE READ THE ABOVE AND UNDERSTAND MY POSSIBLE FINANCIAL RESPONSIBILITY TO FAVOUR DENTAL AND HEREBY AFFIX MY SIGNATURE AS AN ACKNOWLEDGE OF THE UNDERSTANDING.

_____ _____

Signature of Patient, Parent or Guardian, or Legal Representative Date

Please Continue onto back →

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HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledge & authorization. In refusing we may not be allowed to process your insurance claims

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Favour Dental. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS TO BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.

Patient Printed Name: _____

Additional Dependents : _____

_____

Signature (Patient / Legal Guardian): _____

►Please list any other parties who are actively involved in your health care and who can have access to your health information. *(This includes step parents, grandparents and any caretakers who can have access to this patient's records.)*

_____

Name & Relation *Name & Relation*

_____

Name & Relation *Name & Relation*

►I authorize contact from this office to CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

►I authorize INFORMATION ABOUT MY HEALTH to be conveyed via:

☐ Cell Phone Confirmation
☐ Text Message to my Cell Phone
☐ Home Phone Confirmation
☐ Email Confirmation
☐ Work Phone Confirmation
☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize Favour Dental to recommend products or services to promote your improved health. Favour Dental may or may not receive third party remuneration form these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐It was emergency treatment
☐I could not communicate with the patient
☐The patient refused to sign because_____
☐Other (please describe) _____
Signature of Privacy Officer _____