Newburyport Dental Associates

Financial & Privacy Agreement

At Newburyport Dental Associates, it is our goal to provide you with quality comprehensive dental care at a reasonable cost. Payment is due at the time services are rendered unless other financial arrangements have been made with our front office ahead of time. For your convenience, we accept cash, check, Visa, MasterCard, Discover, & American Express. We also offer CareCredit as a financing option.

Insured Patients: As a service to our patients we submit claims to your insurance company for you. It is your responsibility to provide accurate up to date insurance information prior to your appointments. A deposit is required at the time services are rendered- this consists of your deductible and an **estimated** copayment. You are responsible for all fees that insurance does not cover or may deny for any reason.

Non-Insured Patients: Payment in full is due at the time of service.

Cobra & Workman's Comp Claims: We will provide you with any documentation that may be helpful to you when filing your claim; however payment is due to our office at the time of service. Seeking reimbursement by any agency is the responsibility of the patient.

Returned Checks: A $25 fee is charged for a check returned to us by a bank.

Missed Appointments: A $50 fee will be added to your account if 24 hour notice is not provided for the cancellation of a confirmed appointment.

Divorce/Separation: In the case of a divorce or separation, the parent that brings the child to the office is responsible for payment.

Collection and Legal Fees: As the patient, you agree to pay legal and collection fees should your account become delinquent and have to be turned over to a collection agency.

I have read the Financial Agreement and I fully understand my responsibilities.

Signature ✕ _____ Date: _____
(Guardian if patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ✕ _____ have had full opportunity to read and consider this
(Print Patient Name)
consent form and the office notice of Privacy Practices. I understand that by signing this form I am consenting to the use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature ✕ _____ Date: _____
(Guardian if patient is a minor)

Witness Signature: _____ Date: _____