DREEM DENTISTRY
REEM HAJ-ALI, DDS, MS

OFFICE & FINANCIAL POLICIES

When we welcome a new patient to the practice, we also welcome any questions you may have about office policies, insurance, and of course, fees.

Financial Policy: It is our philosophy that quality care should be available to everyone. Before any treatment is performed, we will review the proposed treatment plan and your estimated payment. Payment is due at the time services are rendered. For our patients who have dental insurance we will estimate your coverage and bill your insurance as a courtesy; however, your estimated co-payment is due at the time services are rendered. In the event your insurance company does not pay the expected amount, you will be responsible for the entire balance.

Appointment Policy: When scheduling a dental appointment, that time is reserved for you and we do not double-book our appointments. We only accept walk-in appointments in the event of an emergency. We require notice of at least 2 business days to cancel an appointment. A minimum $50 fee per hour of your scheduled appointment will be incurred for any missed appointments or failure to provide notice.

Records Release: In accordance with Kansas Law related to the release of dental records, it is the policy of this office to transfer patient records to either the new dentist or the patient upon receipt of written request. A fee of $19.00 for x-rays only and an additional $.40/per sheet for treatment notes will be assessed to cover the cost of duplication and/or copying patient records and must be paid in full at the time of request. Release of records is limited to the new dentist or the patient and records will not be released to other individuals (unless the patient is a minor). The original records will be maintained in accordance with HIPAA and still remain property of Dreem Dentistry indefinitely.

Outstanding Balances: The release of dental records does not negate any outstanding balances owed on your account; you are still responsible for all account balances. This office will pursue legal action in order to collect outstanding balances, if necessary, and you will be responsible for any and all costs associated with collecting the debt. In order for us to collect any amounts owed, our organization's representatives, ancillary providers, HIPAA business associates, vendors and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, as well as text messages and/or email using any email addresses provided to us. Methods of contact may include prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

A $25 service fee will be incurred for all returned checks.

We are happy to offer MasterCard, Visa, Discover, and American Express as a payment option.

I understand that I am responsible for all costs of dental treatment regardless of what my insurance carrier may or may not pay. I hereby acknowledge that I have read, understand and agree to the terms of this document; also, this signature will serve as "signature on file" for assignment of insurance benefits.

Print Patient name: _____

_____ _____

Signature of Patient or Guardian Date

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