

## **FINANCIAL INFORMATION**

*Thank you* for choosing us as your health care provider. We are committed to giving you comfortable, quality treatment. We have asked you to complete our medical and dental history forms so that we can give you the best care possible. We now ask you to read and sign our financial policy so that there is no confusion regarding fees in our office.

Payment is expected at time of visit. Our financial coordinator will be happy to assist you in anyway with your financial options prior to your treatment.

For our insurance patients, please provide us with your card so we may photocopy the information. If we are able to accept your insurance company's assignment, we will gladly do so and will provide you an ESTIMATE as a guideline. We can make no guarantee of the insurance companies amount of payment. Claims are submitted promptly after the treatment is rendered, and if not paid by the patient's insurance company by the 91<sup>st</sup> day after treatment, will be billed in full to the patient. Our administrative staff prides itself on helping our patients maximize their benefits and we are always available to answer your questions.

I agree to be fully responsible for total payment of procedures performed in this office, including any portion not covered by my insurance company. I understand that if at any time my account becomes delinquent a finance charge of 1.8% per month will be applied to the total balance. If I default and Dr. Wigley's office refers this contract for collection to an attorney, I agree to pay reasonable attorney's fees and actual court costs.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

## **HIPAA NOTICE OF PRIVACY PRACTICES**

We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions regarding this form, please ask to speak with our HIPAA Compliance Officer in person or by phoning at 772-334-4004.

*HIPAA Notice of Privacy Practices form available upon request.*

Signature below is only acknowledgement that you have been informed of the HIPAA Notice of Privacy Practices form:

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_