**DR NANCY DUGGAN, D.D.S.**
**1522 POINTER RIDGE PLACE #E**
**BOWIE, MD 20716**
**301-249-1102**

# FINANCIAL AGREEMENT

Thank you for choosing **Dr. Nancy Duggan, D.D.S.** for your oral health care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

**ABOUT OUR FEES** Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you. Therefore, we have designed a financial agreement that will ensure we meet this goal. One of our business team members will review your payment options with you before any treatment is begun. To accommodate you, we accept cash, checks, Visa, MasterCard, Discover and American Express.

**INSURANCE/ DENTAL BENEFITS** We will accept assignment of your primary insurance benefits. However, we do require **YOUR CO-PAY & DEDUCTIBLE BE PAID IN FULL AT THE TIME OF SERVICE**. Any account balance is your responsibility whether your insurance company pays for your treatment or not. We will gladly process your insurance claims provided you give us your insurance information. It is your responsibility to inform us of changes in your insurance coverage. It is important that you understand that your insurance policy is a contract between you and the insurance company. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable or customary by your insurance company under the policy your employer has selected. If your insurance company does not cover a service then it is your financial responsibility.

**AMALGAM/COMPOSITE RESTORATIONS** Please be aware that our office recommends the use of composite (tooth colored) restoration materials in treating tooth decay. You, the patient, will always have the option of choosing amalgam (gray metal filling) restoration materials in place of the tooth colored filling material. By choosing the composite material your insurance company may choose reimbursement based on the cost of an amalgam restoration. You would be responsible for the difference between your insurance payment and our fee.

**MISSED OR LATE APPOINTMENTS** Please help us serve you and our other patients better by keeping scheduled appointments and times. Appointments that are missed or canceled without 48-hours notice are then unavailable to patients who need appointments. Missed and cancelled appointments are charged at a rate of $50 per half hour. Please consider your schedule carefully when making appointments.

Thank you for taking the time to read our financial agreement. Our team is committed to providing the best treatment for our patients.

**FINANCE CHARGE**: If I do not pay the entire balance within 60 days of the treatment date a billing charge will be added to the account for the current monthly billing period. The BILLING CHARGE will be 1.5% per month; 18% per annum applied to the last month's balance, in the case of default of payment, I promise to pay any interest on the balance due, together with any collection costs and attorney fees incurred to effect collection on this account.

I have read and understand the financial agreement of **Dr. Nancy Duggan, D.D.S.** and agree to the above arrangements.

Signature ______________________________ Date ______________________________

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT
Dr. Nancy Duggan D.D.S
1522 Pointer Ridge Place
Suite E
Bowie, MD 20716

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
Obtain payment from third-party payers.
Conduct normal healthcare operations such as quality assessments and physician certifications.
I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:
Relationship to Patient: ____________________
Signature: ____________________
Date: ____________________

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Office Use Only
I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices
Acknowledgement, but was unable to do so as documented below:
Date: ____________________ Initials: ____________________
Reason: