



OUR OFFICE POLICIES

Thank you for choosing Raleigh Periodontics and Implant Dentistry. We are committed to your successful treatment and know you may have many questions regarding our office policies. Although all are not listed, the most frequently referenced policies are included below for your information.

Contact Information: Our office makes every attempt to personally answer each telephone call during our normal business hours, (919) 846-2480. Occasionally, our team members are assisting other callers and our voicemail system will direct you to leave a message. If your call is after hours, our voicemail system will again direct you to leave a message or will provide an opportunity to access our emergency call system.

Appointment Policy: All patients are seen by appointment only. We try our very best to stay on schedule, but sometimes emergencies arise and procedures take longer than expected. If there are serious delays, we will try to notify you as early as possible. Coincidentally, we greatly appreciate your punctuality and ask that you notify our office as soon as possible, at least 48 hours in advance, if it is necessary to reschedule an appointment. If a patient is greater than 15 minutes late, it may be necessary for our office to reschedule an appointment.

Website: Our website is routinely updated to provide our patients with the most current information regarding our services and our practice. It also features biographical information about each doctor and provides detailed descriptions of the procedures we provide. Please visit it anytime to obtain more information: www.raleighperio.com.

Financial Policy: Payment is due in full at the time services are rendered. We accept cash, checks, credit cards (Visa, Mastercard, Discover or American Express), Care Credit or Cherry Financing. Our office does not accept dental insurance as a form of payment, but please read our Dental Insurance section for important information on how we can assist you in this area. There is a 2% surcharge if paying by credit card, but no surcharge for debit or check payments.

Dental Insurance: Raleigh Periodontics and Implant Dentistry are not participating providers with any plan and do not accept the amount dental insurance companies pay as full payment for services rendered. If you have dental insurance, please remember to provide your card for duplication. A dental insurance claim will be sent on your behalf after each visit, directing your company to send payment directly to you. Many times, dental insurance companies will request additional information such as dental records, x-rays or narratives which may delay payment. Our office responds to these requests as soon as possible, in order to expedite your reimbursement. Please be aware that some, or perhaps all, of the services provided by our office may not be covered by your dental insurance company.

Medical Insurance: At this time, our office is not equipped with the proper systems to file medical insurance, nor do we accept any medical insurance programs. This includes all Medical or Health Insurance policies and Medicaid. We will be happy to provide you with a dental claim form and dental procedure codes to submit to your medical insurance company yourself, but we are unable to submit or pursue these claims on your behalf.

Medicare Recipients: Neither Raleigh Periodontics and Implant Dentistry nor any of our doctors or hygienists are Medicare providers.

Therefore, we are unable to submit claims to or receive payment from Medicare for any service we provide. Subsequently, you as our patient are not authorized to submit claims to Medicare for any service we render. Some services provided by our office could possibly be covered by a participating Medicare provider. By choosing our practice for your treatment, you agree to be responsible for all charges, as Medicare limits will not apply. This policy may also affect your supplemental benefits.

HIPAA Agreement: Please see separate Notification of Privacy Practices which describes how your personal information is protected by our office. This information is provided to you as required by the Health Insurance Portability and Accountability Act (HIPAA) implemented in April of 2003. You may find this on our website raleighperio.com or posted in our lobby.

Signature: By signing below, I acknowledge I have read, understand and agree to the above information provided by Raleigh Periodontics and Implant Dentistry, including: Appointment, Financial, Insurance, Medicare and HIPAA policies:

SIGNATURE OF PATIENT OR LEGAL GUARDIAN_____

Date_____



CONSENT FOR TREATMENT

1. I hereby authorize Raleigh Periodontics designated staff to take x-rays, study materials, photographs and any other diagnostics deemed necessary by the Doctors.
2. Upon such diagnosis, I authorize Raleigh Periodontics to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to pronounce proper care.
3. I agree to the use of anesthetics, sedatives and other medications as necessary. I understand that using anesthetics embodies certain risks and complications.

Signature of Patient or Authorized Representative: _____ Date _____

AUTHORIZATION TO RELEASE & DISCUSS DENTAL INFORMATION

The HIPAA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care providers, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below. You may opt out by checking the "Do NOT Release Information" box below.

I give the following named person(s) authorization to take messages or speak with the office of Raleigh Periodontics and Implant Dentistry, on my behalf regarding (Please check all items authorized):

Name of authorized person: _____ Relationship: _____

Phone Number: _____

Appointments ____ Financial ____ Dental Treatment ____ Insurance ____ Other (Explain) _____

Name of authorized person: _____ Relationship: _____

Phone Number: _____

Appointments ____ Financial ____ Dental Treatment ____ Insurance ____ Other (Explain) _____

Name of authorized person: _____ Relationship: _____

Phone Number: _____

Appointments ____ Financial ____ Dental Treatment ____ Insurance ____ Other (Explain) _____

____ DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Patient's Name: _____ Date of Birth: _____

Signature of Patient or Authorized Representative: _____

Date Signed: _____