ELITE SMILES
DENTAL LTD
315 W. Wisconsin Ave Appleton, WI 54911
www.EliteSmilesWisconsin.com

Alissa M. Edwards, DDS
920-731-2211
Mark Pflum, DDS
920-733-8309
Dale M. Scharine, DDS
920-733-4787

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Elite Smiles. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Elite Smiles reserves the right to change the privacy practices that are described in the Statment of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY				
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (***PLEASE SPECIFY***):		YES		NO

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained					
PROVIDED PRIOR TO TREATMENT?		**YES**		**NO**	
DATE PROVIDED:					
REASON FOR DENIAL:		**NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.**			
		WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.			
		UNABLE TO SIGN.			
		REASON NOT GIVEN.			
		OTHER (EXPLAIN):			

Please continue on back →

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FINANCIAL POLICY

We are committed to providing you with the highest quality dental care utilizing only the best materials and technology available. In our process of doing so, we have formulated a financial policy to continue to provide you with several options to choose from, in order to meet your financial needs.

DENTAL INSURANCE:

Our office is happy to cooperate with our patients who are covered by dental insurance. However, it is your responsibility to inform us when your policy changes, so we can bill the correct insurance company. We also ask that you **"READ YOUR POLICY THROUGHLY"** so you are fully aware of benefits provided and the limitations imposed. Please call your insurance company if you have any questions concerning your plan. In order to provide you with optimal treatment, each patient is treated according to their individual dental needs; we do not diagnose according to your insurance plans benefits. (Please check with our office to see what insurance plans we are Preferred Providers for).

All incurred charges are ultimately your responsibility, regardless of insurance coverage. Your employer and the insurance company negotiated a contract that "our office" was not involved in. We **DO NOT** control how your benefits are paid or your contractual limitations. What that means is, if you have a concern over what your insurance pays on a dental procedure due to a contractual limitation or a non-covered procedure, you will need to take the issue up with your insurance company and not our office. We will attempt to do all we can to get your insurance to pay; however, all balances not paid by your insurance company are due by you 20 days after you receive our final statement.

PAYMENT OPTIONS:

For your convenience, we accept Visa, Master Card, Discover, Care Credit, Cash & Personal check (must be imprinted with your personal information and from a local bank).

The following is available for patient balances over $350.00 (subject to approval)

1. 3 month Payment Plan: **1/3 Down at the start of treatment.** Leave a Credit Card # for next two (2) payments to be charged on same date in two (2) consecutive months. Post dated personal checks will be accepted. (must be imprinted with your personal information and from a local bank).
2. Interest free payment plans (6 & 12 month options) thru Care Credit. Please see one of our front desk team members to discuss this option.
3. Payment options available for Orthodontic patients. Please see our Financial Coordinator for additional information.

Patient Signature____ Date____________________

POS Reorder # 1507311