

**DIAMOND DENTAL OF OWINGS MILLS, LLC  
FINANCIAL POLICY**

**Overview**

**Patient Name** \_\_\_\_\_

Thank you for choosing our office for your dental needs. We continually strive to provide our patients with the finest care. Dental treatment is an excellent investment in an individual's medical and psychological well-being. We work hard to discuss your dental care, the risks and benefits to various treatments, and associated fees before beginning any treatment. We realize that every patient has different financial situations; therefore, we are prepared to offer our patients a variety of payment options to allow you to receive the dental care that you deserve. To maintain efficient practice operations, and prevent any misunderstanding, we ask that you review our financial policies.

Payment for dental services provided are due at the time of service unless other arrangements have been made in advance. For patients with dental insurance, your deductible and copay are due on the date of service. We will work with you to maximize your insurance benefits, but keep in mind, you are fully responsible for all fees associated with treatment, regardless of insurance coverage.

For your convenience, we accept cash, checks, Visa, MasterCard and Care Credit (third party financing).

When a balance is due on your account, you will receive a monthly statement. After 90 days, any unpaid may be eligible for a collections agency.

Please contact our office if your statement does not reflect your insurance company's payment within the four to six weeks following your treatment. Any remaining balance after your insurance company has paid is your responsibility, and prompt payment is appreciated. Note: Adults 18-26 years old using their parent(s) insurance, financial arrangements are your responsibility, but you may want to include your parent(s) in financial discussions.

**Discounts and Financing Plans**

-Pay As You Go: Simply complete treatment at a pace that is comfortable with your personal finances.

-5% Pre-pay Cash or Check Discount: On treatment greater than \$1500 when paid by check or cash on or before the date of service.

-3% Pre-pay Credit Card Discount: On treatment greater than \$1500 when paid by credit card on or before the date of service.

-Special Service Payment Option: On occasion, the doctor may opt to allow for an extended in office payment plan. This treatment option would allow the patron to spread the payment of treatment over 3 months by paying half of the treatment cost on the date of service, then pay the remaining balance in 2 equal subsequent monthly payment. Month 1 = 50% total balance fee, Month 2 = 25% total balance fee, Month 3 = 25% total balance fee (Paid in Full). This option MUST be agreed upon BEFORE service is rendered.

-Care Credit Healthcare Financing: Healthcare financing allows you the flexibility of applying for several convenient financing plans. Upon completion a short credit application and approval by Care Credit, you may select 3, 6, or 12 months *interest free* financing, or 18-60 month plans from 4.99% to 14.90% depending on your credit score. More information may be found at [www.carecredit.com](http://www.carecredit.com)

I have been presented these options: \_\_\_\_\_ Date: \_\_\_\_\_

Signature or Guardian's Signature

## GENERAL INSURANCE INFORMATION

We are happy that you have dental insurance coverage to assist you in paying for dental services. We want our patients to be comfortable with ALL aspects of their dental care; including financial arrangements. Please see our financial policies for specific information on payments and coverage through our office. Here are some general information points for your reference:

Dental insurance is not always like medical insurance.

- There are NO regulations as to how insurance companies determine reimbursement amounts. There are NO regulations or universal figures for what insurance companies determine “Usual and Customary Rates (UCR)”. Therefore, reimbursements fluctuate widely amongst plans and change from year to year. In addition, insurance companies are not required to disclose how they determine these levels.
- Generally, a dental benefit plan is a contract between the insurance company and your employer or plan sponsor. Terms of dental insurance plans vary widely.
- Plans may suggest that you choose to have dental care providers from one of their “preferred providers.” Receiving care from one of these providers may, or may not, affect the level of monetary reimbursement.
- There are other factors that may affect reimbursement: Insurance companies reserve the right to pay the least expensive alternate and minimal treatment option. They may not pay for what they deem are pre-existing conditions. There are annual maximums; most of which have increased little-to-nothing in the past 40 years. Most companies have a deductible(s).
- If you have more than one insurance plan, it does not mean that you have 100% coverage. Secondary insurers have separate rules about their coordination of benefits. In order to properly process insurance benefits from a secondary insurance company, you must provide our office with the Explanation of Benefits (EOB) from the first or primary insurance company. This is true even if your primary insurance company does not cover or denies benefits for the procedure(s) billed.
- Claim processing schedules vary with each insurance carrier. Some will pay the doctor's office directly, others will expect the policy holder (i.e. you, the patient) to pay the doctor first, and then get reimbursed. If you would like to have our office accept a check that the insurance company has sent you, we require that you sign the check and include the Explanation of Benefits (EOB) for the services billed.
- You can help our office expedite the claims process by replying promptly to any insurance inquiries and calling the insurance company regarding claim status on any services not paid within 45 days of service.
- Our office will always try to give you an estimate of your insurance benefits for services rendered. This is an “earnest estimate”, and NOT a guarantee. There could be a residual balance after the insurance company pays.
- Pre-authorization of treatment is often required by dental insurance companies; however, if you

would like a more accurate prediction of benefits, we would be happy to send your insurance company the appropriate information at no charge to you. This process can take 4-6 weeks. Please note that all insurance companies have a clause stating that they reserve the right to negate previous authorizations for various reasons. Insurance companies will not guarantee payment to you or us.

- When you come to our office for the first time or if your plan changes, please bring your insurance card and any benefit booklet or completed claim you have. It would be helpful bring your insurance card with you whenever receiving care in case there are any questions or changes.

In order to maximize your dental insurance benefits we recommend:

- Know your Yearly Maximum: The dollar-amount that your dental insurance plan will pay for your dental work within a single year. Although the maximum varies among insurance companies, the average is around \$1,000 a year, per person covered under the plan. This renews each year (on the 1<sup>st</sup> of January, if your plan follows a calendar-year), providing another \$1,000 for the next 12 months. If you have unused benefits from the previous year, they won't roll over to the next year. Get your money's worth and utilize your maximum benefits within each year.
- Know your Deductible: This is the term for the amount of money you have to pay your dentist "out-of-pocket" before your insurance company will pay, to take care of your teeth. Again, the amount varies between insurance companies and their plans, and it could be costly if you choose an "out-of-network" dentist. If you have already paid your deductible for this year, and do not believe you need to see the dentist again this year, think again: your deductible will start again next year.
- Take Advantage of your Benefits: Even if you do not have a cavity, and are not in need of a root canal, be sure to regularly schedule your dental cleanings. These scheduled-cleanings, when followed, help prevent, and can detect, early signs of cavities, gingivitis, oral cancer, and other dental issues.
- Do not Avoid Problems: If you decide to delay treatment for what might be a simple cavity, you risk a more extensive and expensive treatment down the line. You may think that your "simple toothache" is nothing of consequence, when it is actually a cavity waiting to worsen into a root-canal.

## Office is Non-Restricted Dental Practice.

Our office is a **non-restricted** dental practice. Many of our patients have dental insurance, and we pride ourselves in helping them maximize their benefits. We work with any plan that allows you the **freedom to choose** any dentist. Usually this type of plan is called a PPO plan. Do you know what type of plan you have?

A participating or “in-network” dentist is working FOR the insurance company. Hence, the term “contracted” dentist. The contract governs what dentist will receive as a discounted payment for limited services. Keep in mind that participating dentists need to see a volume of patients to close the monetary gap that the insurance company leaves open. In many cases, the quality of care can be affected due to the fact that they have to see more patients to cover their overhead. Procedures may be recommended which are more costly (i.e. a crown instead of a crown). Treatment can be guided by covered procedures and fee schedules rather than by chosen treatment plan by the patient and the dentist. For example, x-rays may be taken more frequently or in higher quantities than needed just because “they are covered,” not because they are needed.

A non-participating dentist is working FOR YOU! They is not willing to accept the much lower payments for procedures, and are not willing to sacrifice the quality of care in order to see volume of patients and play games with insurance coding. By not participating, decisions regarding your treatment are made between you and your dentist based on your dental needs and desires rather than the plan restrictions of the insurance policy.

Of course, the insurance companies encourage you to see participating providers, as it keeps more money in their pockets.

The bottom line is, chose a provider that you trust, feel comfortable with, and provide you with the quality care and stands by the quality of their work! After all, you are the patient and you have a choice. Although many of our patients do not have dental insurance, many of those who do have dental insurance have chosen our practice for all of these reasons.

# DIAMOND DENTAL OF OWINGS MILLS, LLC

**Monica M. Mattson, D.D.S.**

**HEALTH HISTORY (Confidential)**

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_ Date of Last Dental Exam: \_\_\_\_\_ X-Rays: \_\_\_\_\_  
 What is the reason for your visit? \_\_\_\_\_  
 Do you consider yourself in good health? \_\_\_\_\_ Physician: (name/contact info) \_\_\_\_\_  
 Are you happy with your smile? \_\_\_\_\_  
 Have you ever smoked or used tobacco (circle) products? \_\_\_\_\_ How long? \_\_\_\_\_ Qty/day? \_\_\_\_\_  
 Do you still smoke or use tobacco (circle) products? \_\_\_\_\_ How long? \_\_\_\_\_ Qty/day? \_\_\_\_\_  
 Have you ever had an oral cancer exam? \_\_\_\_\_  
 Are you pregnant? \_\_\_\_\_ How many weeks? \_\_\_\_\_  
 Do you suffer from migraines or muscle tension headaches? \_\_\_\_\_ How often? \_\_\_\_\_  
 Are you aware of clenching or grinding of your teeth? \_\_\_\_\_ Have you worn/wear (circle) a nightguard? \_\_\_\_\_  
 Do you have a history of periodontal (gum) disease? \_\_\_\_\_  
 Have you ever had "deep cleanings" or root planing of your teeth? \_\_\_\_\_ When? \_\_\_\_\_  
 Have you ever been pre-medicated before dental appointments? \_\_\_\_\_ Antibiotics? \_\_\_\_\_ Anxiety? \_\_\_\_\_  
 Do you have a dry mouth? \_\_\_\_\_  
 Do you drink sodas or sports drinks? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you chew gum, chew ice, bite nails, suck on hard candy or cough drops (circle)? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you get fever blisters or cold sores? \_\_\_\_\_ How often? \_\_\_\_\_  
 Are there any other health issues we should know about? \_\_\_\_\_  
 Health History Updates \_\_\_\_\_

**CONDITIONS: Circle Conditions that you HAVE or HAD in the past.**

Condition	Please Explain	Condition	Please Explain
Acid Reflux/GERD	_____	Herpes	_____
AIDS	_____	High Blood Pressure	_____
Alcoholism	_____	AIDS / HIV Positive	_____
Anorexia	_____	HPV	_____
Asthma/Inhaler	_____	Joint Replacement/Date	_____
Bleeding Disorder	_____	Kidney Disease	_____
Blood Transfusion	_____	Liver Disease	_____
Bulimia	_____	Migraine Headaches	_____
Chemical Dependence	_____	Pacemaker/Defibrillator Implant	_____
Cancer/Type/Treatment	_____	Psychiatric Care/Medication	_____
Diabetes/Type/Controlled?	_____	Subacute Bacterial Endocarditis	_____
Emphysema	_____	Stroke / T.I.A.	_____
Epilepsy	_____	Thyroid Problems	_____
Heart Disease	_____	Tuberculosis	_____
Heart Murmur	_____	Ulcers	_____
Hepatitis/Type	_____	Other	_____

**Patient is responsible for notifying the dentist of any changes in their health or medications. Initials** \_\_\_\_\_

**MEDICATIONS:** (List of medication and dosages currently taking) \_\_\_\_\_

**VITAMINS, SUPPLIMENTS, RECREATIONAL DRUGS:** (What and how often) \_\_\_\_\_

**ALLERGIES:** (To medications or substances) \_\_\_\_\_

Do you have any scheduling preferences? \_\_\_\_\_

Morning, Afternoon, Evening, Weekends (circle)? M, Tu, W, Th, F, Sa? ONLY?

Communications preferences (circle)? Email, Text, Home Phone, Cell Phone, Written, Language

Personnel Requests? \_\_\_\_\_

Do you require any special needs while receiving care here? \_\_\_\_\_

Ex. wheelchair access, no stairs, blanket, no music, headphones

# Notice of Privacy Practices

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**Purpose:** This form, Notice of Privacy Practices, presents the information that federal law requires us to give our patients regarding our privacy practices. {Note: this form may need to be changed to reflect the dental practice's particular privacy policies and/or stricter state laws.}

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after April 14, 2003. We must make a good-faith attempt to obtain written acknowledgement of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting a Notice. We must also post the revised Notice in our office as discussed above.

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{NAME OF PRACTICE}

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# NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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## **OUR LEGAL DUTY**

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect \_\_\_/\_\_\_/\_\_\_, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

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## **USES AND DISCLOSURES OF HEALTH INFORMATION**

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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## PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.\_\_\_\_ for each page, \$\_\_\_\_ per hour for staff time to copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restriction:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

Address: \_\_\_\_\_

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**Insurance Notification of Payment Directly to the Patient**

Your insurance policy is an agreement between you and your insurance company. Our office is not a party to that contract. Accordingly, your insurance company has stated that they will only send payment for "covered services" directly to you, the insuree. Diamond Dental of Owings Mills will file your insurance claim for you. We ask that you pay the deductible and estimated co-payment on the date of service. We are willing to wait for you to be reimbursed from your insurance company and we will cooperate fully with the regulations and requests of your insurance company that may assist with your claim. Once your insurance company has paid their share, a statement will be sent to you for the balance due. Please send payment at that time, along with a copy of the Explanation of Benefits (EOB) within 10 days so we can ensure all claims were paid to you. If your insurance company has not made payment within 60 days from the date of service, the unpaid balance becomes your responsibility.

I have read and understand the above information.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

**DIAMOND DENTAL OF OWINGS MILLS, LLC**  
**Monica Mattson, D.D.S.**

**WELCOME...**as a new patient to our practice, we would like to welcome you. If you are an established patient, we want to thank you for the trust you have placed in Dr. Mattson and our dental team.

**YOUR TREATMENT PLANNING...**it is our policy to provide the best dentistry for you. To do this, it is important that we do not allow dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your needs, and we assume you are as concerned as we are about maintaining your good health.

**DENTAL INSURANCE...**the term is misleading. What is commonly known as “dental insurance” is more correctly termed dental benefits. Dental benefits are not intended to pay for everything, but to assist with costs of dental treatment. Generally, dental benefits pay a percentage of some procedures up to a set yearly maximum (most of which have remained the same since the early 1970's). The benefit available to you are established by which plan package your employer has purchased, and may change annually.

**IMPORTANT INSURANCE INFORMATION...**we recommend that you contact your insurance company for benefit information as all policies differ. Monica Mattson, D.D.S., is not listed as a “preferred provider” or “in network” for any insurance plan; however, as a courtesy to our patients we will submit claims to ALL insurance companies. We also accept benefit assignment, meaning that we will estimate the expected benefit payment and allow you to pay your estimated portion. Please be prepared to put a percentage of your visit down along with your deductible when services are rendered. Once your insurance has paid its allowable amount, you will be responsible for the remaining balance. We do not guarantee any estimate, and we take no responsibility for any denials by the dental plans, as your plan is a contract between you and your insurance company, not us. If your insurance pays the subscriber of the policy directly, we ask that payment be made on the date of service unless financial arrangements have made in advance. **Initials** \_\_\_\_\_

**PAYMENT...**we feel that everyone benefits when definite financial arrangements are agreed upon. For your convenience we offer several financial arrangement options. We accept personal checks, cash, Visa, MasterCard, Discover, and American Express. We also offer affordable payment plans though Care Credit third party financing. **Initials** \_\_\_\_\_

**APPOINTMENTS...**for your convenience we offer a wide variety of office hours Monday, Tuesday, Wednesday, Thursday and some Friday and Saturday mornings. Ask about possible early morning and evening weekday hours.

**CANCELLATIONS...**we try to be respectful of our patient's time when scheduling appointments. Likewise, we ask you respect the time of our other patients and staff members. Please call our office as early as possible if you are in need of a schedule change or delay. Any appointment canceled with less than 24 hours of notice or a missed appointment may be subject to a \$50 fee. **Initials** \_\_\_\_\_

**PATIENT CONFIDENTIALITY...**our office is in compliance with the Federal “HIPPA” Health Insurance Portability and Accountability Act. We will not share your information with anyone other than your insurance carrier, pharmacist, physician, or other dental specialist. I have been given a copy, or have been made available the office’s entire HIPPA policy. **Initials** \_\_\_\_\_

**I have read and understand the above policies.**

\_\_\_\_\_  
Printed Name:

\_\_\_\_\_  
Patient Signature (or Guardian signature)

\_\_\_\_\_  
Date: