PAUL S. Yi, D.D.S., P.A.

516 N. Rolling Road
Suite 102
Catonsville, MD 21228
(410) 744 -3446

1414 N. Crain Highway
Suite 2A
Glen Burnie, MD 21061
(410) 766-3900

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

AUTHORIZATION FOR SIGNATURE ON FILE

Release of Information/Financial Responsibility/Authorization for Payment

Patient (Beneficiary) _____

Insured Name _____

Responsible Party Name _____

I, _____ hereby authorize the office of Paul S. Yi, D.D.S., P.A. to affix my name to any and all claims or documents as related to any and all Dental Health Benefits due to me and my dependents through my Dental Insurance provider _____. I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Paul S. Yi, D.D.S., P.A.

I agree to be responsible for all charges for dental services material not covered by my dental insurance provider.

I authorize the release of any information relating to the claim.

I authorize the office of Paul S. Yi, D.D.S., P.A. to file a complaint on my behalf with the insurance commissioner, if necessary.

Insured/ Responsible Party Signature _____
OR
Patient Signature _____

Date _____ Witnessed by _____

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CATONSVILLE, MD 21228

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1414 N. CRAIN HWY SUITE 2A
GLEN BURNIE, MD 21061

*** FINANCIAL POLICY ***

SELF PAY PATIENTS: Full payment for all dental procedures is expected the day of service. We accept cash, checks, MasterCard, Visa, Discover, American Express, and CareCredit. Please note that there is a returned check fee of $35.00 for non-sufficient funds. Any account balance not paid within 30 days of treatment date will be subject to a re-billing charge.

INSURANCE PATIENTS: We must have a current copy of your insurance card with identification numbers visible. As a courtesy we will file your dental insurance claims on your behalf. Please keep in mind that while we do offer this courtesy, your dental insurance policy is a contract between your employer and your insurance company. We are not a party to that contract. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as mediator with the carrier or your employer.

We file claims to many different insurance companies and it is virtually impossible for us to know your individual insurance policy. Please be aware that some of the services we provide may be considered by your insurance to be a NON COVERED service or not payable by your insurance company.

DUAL INSURANCE PATIENTS: The secondary coverage is supplemental to your primary coverage. Upon receiving your primary dental claim payment, we will send the secondary insurance claim on your behalf as a courtesy. The payment will be mailed directly to YOU, not our office. Because of this we will ask for payment in full for co- pays at each visit. Your secondary insurance will reimburse you directly. This means we will collect the estimated co-pay in full at the time of service according to your primary coverage.

ALL dental claims will be submitted immediately and benefits expected are to be paid within 60 days. The filing of an insurance claim does not relieve you of timely payments on your account. If the claim is not cleared by your insurance carrier in 60 days, the unpaid portion will automatically become your responsibility, and a statement will be issued for the balance on your account. We ask that all statements be paid by the due date on the statement.

TREATMENT PLANS: We will do our best to give you a **close estimate** of your investment in your dental health for each upcoming visit, based on your individual treatment plan. Your treatment plan will be tailored to your oral health needs and is NOT based on dental insurance benefits or lack of benefits. Our staff is trained to help you with questions you may have relating to how your claim was filed or regarding any additional information your insurance carrier may need to process your claim. Please ask if you have any questions. Please note we give **ESTIMATES** only, we do not guarantee any co-pay amounts.

BY SIGNING HERE, I AGREE TO THE ABOVE FINANCIAL POLICY

_____DATE_____