Steven J. Hutchinson, DMD ~ Jennifer P. Hutchinson, RDH
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Written Financial Policy

Welcome! Thank you for choosing Hutchinson Family Dentistry, LLC.

Our primary mission is to provide patients with the very best dentistry available. We want our patients to feel at home and part of our family, building a foundation of trust from the start. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible.

Insurance: Hutchinson Family Dentistry is in network providers for the following insurance companies:

*Cigna PPO (GEHA)
*Delta Dental PPO
*Delta Dental Premier

We file all dental insurance as a courtesy for you. You are responsible for your patient portion that is not covered and your deductible if it applies at the time of service. If we are unable to verify your insurance full payment will be required at the time of service.

Payment Options: Hutchinson Family Dentistry prefers cash or check; however we can accept the following payment options.

*Cash, Check, Visa, MasterCard, Discover, American Express, and Care Credit

Please note:

If the balance on your account reaches **60** days overdue we charge a **5%** late fee, (or a minimum of $5.00 per statement period), that will continue to be added to your account monthly until the account is settled.

Accounts are referred to an outside collections agency after **90** days past due. An additional amount of **37%** will be added to the overdue balance. In the event any type of collection procedures become necessary, you agree to pay for any collection, legal, or attorney fees incurred for you, if applicable, your dependents.

There is a $50 fee for returned checks.

A fee of $100 per scheduled hour is charged for patients who no show or cancel without 24 hours notice.

_____
Patient, Parent or Guardian Signature Date

_____
Patient Name (Please Print) Date

Compound Authorization for Release of Information

Name of Patient _____ **Date of Birth** _____

Hutchinson Family Dentistry, LLC is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. I consent to the following:

Entity to Receive Information	**Description of information to be released**
Voice Mail Text Message Email	Family billing information Appointment information Financial
Give information to school	Appointment absentee information Appointment information
Spouse	Family billing information Financial Medical Appointment information
Parent Legal Guardian	Family billing information Financial Medical Appointment information
Other (provide name) _____ _____ Phone number_____	Financial Medical Appointment information

Rights of Patients

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Hutchinson Family Dentistry, LLC. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient in writing.

_____ Date _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (attach necessary documentation)

Please print name here:

_____