

Troy L. Long, D.D.S.
229 West Gay Street
Lebanon, TN 37087
Office 615.444.2782
Fax 615.444.4354

Office Financial Policy

Payment for services are expected and due at the time the services are provided. For your convenience, we accept CHECKS, CASH, VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS, DEBIT/BANK CARDS. We will offer a 5% Cash discount for treatment paid in advance in full by the method of cash or check.

Regarding Insurance

We will attempt to verify your insurance coverage and calculate your deductible and co-payments as accurately as possible. All services rendered are charged directly to the patient, and the patient (and/or responsible party) is ultimately responsible for the account regardless of insurance coverage. Please understand that your insurance policy is a contract between you and your insurance company. It is not up to us to determine what services they will and will not cover.

As a courtesy to you, we will file your insurance for you, and we may accept direct payment from most insurance companies. **If you have a deductible and/or a co-payment you will be required to pay it at the time the services are provided. Failure to collect a patient's deductible and/or co-pay is considered insurance fraud.** Once payment is received on your claim, we will send you a bill for any balance remaining on your account. Payment will be due upon receipt. Please note that if your insurance has not paid within 60 days, you will be responsible for your account balance.

Past-Due Account Balances

Interest of 1.5% per month (18% annual rate) will be charged to accounts over 60 days. Accounts over 90 days past due may be reported to the Credit Bureau of North America and Experian. A late fee up to \$50.00 may be applied to accounts over 90 days. Patients will be responsible for all collection cost, court cost and/or attorney fees which could incur as a result of collecting on an account that has been turned over to a collection agency.

Payment Plans

We do offer payment plans for those with approved credit* through a third party financing company (Care Credit/ Chase Health Advantage). Please see a member of our front office team for more information.

I have read and understand the above financial policy. By signing below, I acknowledge responsibility and agree to the terms as stated above.

Signature of Patient/or Responsible Party

Date

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PATIENT CONSENT & ACKNOWLEDGMENT FORM

By signing below, you consent to the use and disclosure of your protected health information by Troy L. Long, D.D.S., our staff, and our business associates for treatment, payment, and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices. You have the right to review our Notice of Information consent. The terms of this notice may change. If the terms do change, you may obtain a revised notice by simply contacting our office at 615.444.2782 and requesting a revised notice. We will also post any revised notice in our office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the rights to refuse to treat you, should you choose to refuse to disclose your Protected Health Information (PHI).

THIS FORM IS ALSO USED TO OBTAIN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES OR TO DOCUMENT OUR GOOD FAITH EFFORT TO OBTAIN THAT ACKNOWLEDGEMENT.

I HAVE REVIEWED, UNDERSTAND AND AGREE TO THE CONTENT OF THE NOTICE OF PRIVACY.

NAME

DATE

PLEASE SPECIFY THE EXACT REASON WHY PATIENT CHOSE NOT TO SIGN THE
CONSENT/ACKNOWLEDGEMENT OF NOTICE OF PRIVACY.
