



Lindsay B. Eastman, D.D.S., M.S., P.A.

Periodontal Specialist and Dental Implants

Notice of Privacy and Financial Guidelines

Welcome to the office of Dr. Lindsay Eastman, Periodontal and Dental Implant Specialist. Our financial goal is to offer state of the art treatment at an affordable investment leading to improved oral health.

Courtesy Insurance Filing Service:

Our office strives to offer the highest level of care to our patients and does not belong to any dental insurance plans. We base our recommendations on the *needs of our patients* rather than the *limitations of insurance benefits*. As a courtesy and convenience to you, we will file your claims for all services and procedures with your dental insurance company. Sometimes your policy will not pay for services, testing or medications that we may feel are medically recommended. Since coverage rules change often, it is not possible for us to always know what your particular coverage may be. We advise you to acquaint yourself with your policy and to call your insurer regarding any coverage questions. We will always work with you to do the best for your health and well-being, and we look forward to sharing the benefit of our years of experience with you. For more information on what your insurance may or may not pay, please visit us online at www.eastmanonline.com/insurance

Payment at Time of Service:

Please provide payment at the time the service or procedure is performed. For your convenience, we accept Visa, MasterCard, Discover, American Express, check or cash. For patients without insurance, *Capitol One Healthcare Finance* is available and affordable for any budget.

Missed Appointments:

If you cannot keep your scheduled appointment, please let us know at least 24 hours in advance. There will be a \$25 fee charged for appointments missed without 24-hour notice, except in the case of an emergency.

Fee for Returned Checks:

For checks written in payment of our services, which are returned for insufficient funds, there will be a \$25 processing charge.

Questions?

If you have any questions about your financial responsibilities or our payment guidelines, please do not hesitate to ask. We look forward to getting to know you and to enjoying a win-win relationship with you.

Dental Insurance Signature on File:

I, the undersigned, have insurance with the carrier named on the insurance information document prepared by me today. I will notify this office immediately of any changes to my insurance coverage. I authorize payment of dental benefits directly to Dr. Lindsay B. Eastman for professional services rendered. I am financially responsible for all charges for such services rendered to me, including the balance remaining after the payment of any insurance benefits. I permit a copy of this authorization to be used in place of the original, and authorize the release of any dental or other information necessary to process a claim on my behalf.

Permission to treat:

I hereby give Dr. Lindsay B. Eastman permission to treat me as a patient. I shall comply with his recommendations for treatment, tests and/or referrals to other specialists as may be necessary for my care. My non-compliance with recommended treatment may result in my discharge from this practice.

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Release of Dental Information:

I authorize the release of any and all dental information necessary to process this claim.

Fax clearance:

I give my permission to fax any and all records with the understanding that there is a possibility that this information may be misdirected.

Exclusions:

I have listed below the people to whom I **do not** want Dr. Lindsay B. Eastman to disclose any part of my medical or health information:

Notice of Privacy Practices Acknowledgement:

I hereby acknowledge that I have seen the "Notice of Privacy Practices" for Dr. Lindsay B. Eastman displayed in the waiting room and that I have been given an opportunity to ask questions concerning the "Notice of Privacy Practices" and understand that I may have a paper copy should I so desire. A copy of this policy will be made available upon my request.

Financial Agreement:

I understand that I am directly responsible for my account, the payment of this account and I hereby assume and guarantee payment of expenses incurred by myself and/or my dependants. Should legal action be required to secure payment of this account, I agree to pay reasonable collection expenses, all court costs and a reasonable attorney's fee incurred thereby.

Compliance Statement:

I have read and I understand the financial guidelines above and I agree to abide by them.

Patient or Responsible Party

Date