Chad E. Byler, D.D.S., P.A.

Acknowledgement of Receipt
Notice of Privacy Practices

By signing below, I acknowledge that I have received or reviewed the Notice of Privacy Practices (H.I.P.A.A.), I agree with the terms of this notice and understand my rights under this notice. By signing below, I consent for the use of my personal health information for treatment, payment, operations, and other uses as described in the privacy notice. I also understand that I have the right not to sign this agreement.

Patient's Name (Printed): _____

Date: _____

***Signature for H.I.P.A.A.:** _____

Please list the names of family or friends that you will allow us to share your private health information with:

_____

_____

_____

CHAD E. BYLER, DDS, PA, 201 HUNTERS CROSSING BLVD., STE 16, BASTROP, TX 78602

Financial Policy

Thank you for choosing us as your dental health care provider. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following payment options.

Payment is expected at the time of service. We accept cash, approved checks, Visa, MasterCard, and Discover. If extensive treatment is recommended, we offer no interest and extended payment plans through Care Credit. We will assist our patients in the application process. Returned Check Fee is an additional $25.00.

We understand dental insurance, and will gladly assist you in obtaining the maximum benefit as specified by your contract. It is important, however, that you are aware of the following:

1. Your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. In order to file and estimate your benefits, it is important that you provide us with the necessary information. (Claims address, telephone numbers, group/policy numbers, and benefit information). As a courtesy to you, we will file your primary insurance claims.
2. Not all dental services are a covered benefit in all contracts.
3. **You (not the insurance company) are responsible for all of our fees.**
4. If your insurance company does not pay your claim within 60 days from the date of service, we will require that you pay the balance in full and have your insurance company pay you directly.
5. For our patients with insurance, we will provide you with an ESTIMATE OF BENEFITS that the primary insurance company is expected to pay. Any co-payment or deductible is expected at the time treatment is rendered.
6. If your insurance company will not pay us directly, you will be responsible for all fees at each appointment.
7. If you have secondary insurance, you are responsible for filling claims and collecting any benefit.

Our goal is to provide you with quality dental care and personal attention. Your appointment is reserved exclusively for you. In the event that missed appointment and/or changes in your schedule occur, a fee based on the time scheduled and appointment value may be charged to your account (minimum $100 per hour). In addition, you may be required to make a non-refundable deposit to reserve future appointments. The deposit will be applied to your treatment as long as you do not miss or change your appointment without 48-hour notice.

In the event that your account is turned over to collection agency, you are responsible for the balance, and finance charges, as well as all collections and or attorney's fees.

Due to Safety and HIPPA Guidelines only patients with appointments are allowed in the operatory area unless requested back by the doctor. This includes parents and/or guardians for minors.

I have read and understand the above information. I have been provided a copy for my records at my request.

Print Name: _____

Date: _____

Signature for Financial Policy: _____

CHAD E. BYLER, DDS, PA, 201 HUNTERS CROSSING BLVD., STE 16, BASTROP, TX 78602

HIPAA Release Form

I want Chad Byler, DDS to communicate with me via email, phone, text, mail or other media about products or services/appointments that pertain to my conditions or that can contribute to matters related to my health and/or my medical treatment. I understand my Protected Health Information may be referenced to determine that I may be a likely candidate for products or services that my dental health practitioner may share with me.

Chad Byler, DDS may communicate with me about my oral health, treatment, appointments, and post-operative follow-ups by mail, email, text or by phone to the contact information on file. It is my responsibility to ensure all my contact information is up to date.

I understand that communication between Chad Byler, DDS and I may not be encrypted and my information could be intercepted by unauthorized persons.

Chad Byler, DDS will not be responsible for any unauthorized interceptions. However, we will make reasonable measures to ensure proper delivery or notification of our patient's information. Examples include, but are not limited to, post-operative phone calls and appointment reminders.

This consent remains in effect until expressly revoked (in writing).

Printed Name: _____

Date: _____

*Signature for HIPAA Release Form: _____