RICHARD L. DAFFURN, D.D.S.
SONOMA MEDICAL PLAZA
181 ANDRIEUX ST., STE 104
SONOMA, CA 95476
Phone (707)996-4585
Fax (707)996-4059

PATIENT NAME:_____**BIRTHDATE:**_____

OFFICE FINANCIAL POLICY

BASIC POLICY Payment for service is due in full at the time of the service provided in our office.

MISSED APPOINTMENTS In fairness to other patients, the hygienists, staff and the doctor, we require at least 48 hour's notice to cancel or change an appointment. A $75 charge may be assessed for missed or failed appointments or you may be dismissed from the practice. **INITIALS:**_____

FOR PATIENTS WITH INSURANCE As a courtesy for our patients, we will bill most insurance carriers for you if proper paperwork and information is provided to us. Kindly provide **all** of the information below or payment will be expected at the time of service. We will also bill most secondary insurance companies for you. All co-payments and deductibles are due in full at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid. If your insurance company has not paid within 60 days of billing (for any reason), professional fees are due and payable in full from you. Your insurance carrier may require pre-authorization for some procedures to be covered. We will assist you but cannot be responsible for too little or non-payment from your insurance company.

NON-COVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

I have read, understood and agreed to the above financial policy for payment of professional fees. **I am ultimately responsible for all professional fees.**

Signature_____Date_____

INSURANCE INFORMATION

PRIMARY INSURANCE:

PATIENT NAME _____

EMPLOYEE NAME _____

EMPLOYER _____

NAME OF INSURANCE COMPANY _____

ID #_____**GROUP #** _____

SS # OF EMPLOYEE _____**EMPLOYEE BIRTHDATE** _____

BILLING ADDRESS OF INSURANCE COMPANY _____
_____

PHONE NUMBER OF INSURANCE COMPANY _____

SECONDARY INSURANCE IF APPLICABLE:

EMPLOYEE NAME_____

EMPLOYER_____

NAME OF INSURANCE COMPANY_____

ID #_____**GROUP #**_____

SS # OF EMPLOYEE_____**EMPLOYEE BIRTHDATE**_____

BILLING ADDRESS OF INSURANCE COMPANY_____
_____

PHONE NUMBER OF INSURANCE COMPANY_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all dental benefits, private insurance and any other health plans to Richard L. Daffurn, D.D.S. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not aided by said insurance. I hereby authorize said assignee to release all information necessary to secure payment and relating to this claim.

Signature_____Date_____

CONSENT TO RECEIVE UNENCRYPTED EMAIL

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. However, you may consent to receive email from us confirming appointments or regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

_____ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email addresses is_____.

_____I consent only to receive appointment reminders via email. I understand I can withdraw my consent at any time. My email addresses is_____.

_____I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

Signature_____Date_____