Office Policies & Authorizations

Payment for Services

For your benefit, we offer several payment and financing options at Dr. Lori Lemire Family Dentistry. We accept most major insurance plans and our experienced staff will gladly assist you in obtaining the maximum benefits your plan provides. Contact us at (541)267-6425 with any questions you may have about insurance or financial options.

Method of Payment

We accept Cash, Check, Visa or MasterCard. We offer a 5% discount for payment on day service (Cash or check only). For patients without insurance coverage, we expect payment in full at the time of service. As a condition of your treatment in our office, financial arrangements must be made in advance.

Billing for Insurance Accounts

At each visit, we will estimate your insurance coverage and will ask you to pay the difference at the time service is rendered. If there is an additional balance after the insurance claim is paid, you will be responsible to pay that balance within 30 days.

Filing insurance claims is a courtesy that we extend to our patients. All charges are your responsibility from the date that service is rendered. If we have not received payment from your insurance carrier after 60 days, we will ask you to pay the remaining balance and ask you to discuss your claim with your insurance company.

Financing Options

Sometimes procedures have to be performed unexpectedly and we understand that. Please discuss your situation with our financial coordinator. For our patients who wish to extend payment plans over a longer period of time, we do offer other payment options including **Care Credit**. **Care Credit** is a convenient, low monthly payment plan for dental treatment over $1,000.00. For more information about this payment option, visit Care Credit's website.

New Emergency Patients

All new emergency patients must pay in full at the time of service.

Fee Estimates

I understand that the fee estimate listed for a given dental treatment plan can only be extended for a period of one year.

Appointment Failures and Cancellations

We require a 24-hour notice of change of appointment or cancellation. If you fail to keep your appointment or haven't given us 24 hours notice, you will be charged $75.00. We appreciate you as a patient. Your cooperation in complying with this policy assists us in providing the best care possible to all our patients.

Truth in Lending Disclosure: **In accordance with the Federal Truth-In Lending act, we are providing the following information about our credit and fee policy:**

1. Patient portion is due at the time of service.
2. Balances extended beyond 60 days from date of the first billing will be subject to a finance charge of 1.5% per month (annual rate of 18%).

3. There will be a $75.00 charge for cancellations or failure to show up for an appointment with less than 24 hours notice.
4. There will be a $25.00 charge on all returned checks.

Assignment of Insurance Benefits: I hereby authorize Dr. Lori Lemire Family Dentistry to submit claims to my insurance carrier for all services rendered. I direct third party payers to issue payment directly to Dr. Lori Lemire Family Dentistry

Authorization to Release Information: I authorize the release of any information concerning me (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

Financial Responsibility: I understand that is my responsibility to provide complete, accurate, and timely information on my insurance coverage(s). In the event that my insurance coverage does not pay, for any reason, I understand that I will be financially responsible for the dental services received.

Authorization to Perform Procedures: I authorize Dr. Lemire and her staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Authorization to Transfer Records: I authorize Dr Lori Lemire Family Dentistry to transfer records when necessary on my behalf.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE LISTED OFFICE AND FINANCIAL POLICIES OF THIS DENTAL OFFICE. I UNDERSTAND THAT I AM RESPONSIBLE OF ALL COSTS OF DENTAL TREATMENT. I HAVE ALSO RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES (HIPPA).

_____ _____

Print Full Name Date of Birth

_____ _____

Signature Today's Date

Authorization is valid until specifically revoked in writing

for office use only:
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers or an emergency situation prohibited obtaining acknowledgment
- The patient refused to sign
- Other (please specify)_____