Financial Policy

1. We accept cash, checks, Visa, Mastercard, American Express and Care Credit.
2. A fee of $45 will be charged for any returned check.
3. Your estimated portion of service is due the day of service. We will bill your insurance company, and upon processing will bill if further balance is due. We will also promptly refund money if our initial estimation was inaccurate.
4. Any balance over 60 days will be subject to a collection fee and will then be turned over to a collection agency unless previous arrangements have been made.
5. You understand that you forfiet any discounts given if the account is past due.

Privacy Policy

I have been given the opportunity to evaluate the privacy policies of Nephi Smiles. A separate form regarding my patient rights, as pertains to the rules and regulations of HIPAA (Health Insurance Portability and Accountability Act), has been provided to me (available online or at check-in, as well as upon request). I authorize Nephi Smiles to use or release my health information to third party payers or other health practitioners as reasonably necessary for my treatment and reimbursement therof.

I assume all financial responsibilty for all patients listed below. I understand that any treatment plan given is an estimate ONLY based on insurance information.

I, the patient or responsible party, understand and agree to the above office policies.

Responsible Party (Please Print): _____

Responsible Party Signature: _____Date_____

Patients covered under this policy:

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