James A. Whitley, DDS & William A. Benson, IV, DDS
309-181 W. Millbrook Rd. Raleigh, North Carolina 27609
(919)789-0400

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for James A. Whitley DDS/William A. Benson, DDS to furnish dental care and treatment to ______________________________ that is considered necessary and proper.

Patient/Guardian____ Date___________

HIPPA NOTICE OF PRIVACY PRACTICES

We understand that health information about you is personal. We are committed to protecting health information about you. We are required by law to 1) make sure that health information that identifies you is kept private 2) give you the opportunity to receive a full copy of our legal duties and privacy practices with respect to health information about you 3) follow the terms of the privacy notice that is currently in effect.

I have received a copy of the privacy practices.

Patient/Guardian____ Date_____________

I have declined the copy of the office privacy practices.

Patient/Guardian____ Date_____________

E-MAIL CONSENT

I hereby grant permission to e-mail appointment confirmations and any pertinent information to my e-mail address which is____.

This single address will apply to my entire family if applicable. This consent also will apply to sending information and x-rays via e-mail to other providers that are deemed necessary.

FINANCIAL POLICY STATEMENT

We bill insurance carriers solely as a courtesy to you. You are responsible for the entire bill regardless if insurance is in effect or not. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments, you will be responsible for the amount of money refunded to your insurance. It is your responsibility to know your insurance benefits and to provide us with the necessary and correct information to file your claim. If your insurance changes we must be notified of the change and you must investigate with your carrier as to whether or not you will be able to have treatment in our office. There are numerous plans available under the same carrier and it is impossible to know the details of every plan. Every effort will be made to help you through this process but it is ultimately your responsibility to know your plan details.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian____ Date____________

PRETREATMENT ESTIMATES

Pretreatment estimates are usually valid for 90 days provided the patient has not exceeded the yearly maximum and remains covered by the dental program. Every effort will be made to give accurate contract benefits and payment information. However, knowledge of contract provisions and/or limitations is ultimately the responsibility of the patient. INSURANCE PRETREATMENTS ARE ONLY AN ESTIMATION OF BENEFITS NOT A GUARANTEE.

I understand that if a pretreatment is filed in my behalf that my insurance may not accurately honor the original paperwork and I would be responsible for any differences.

Patient/Guardian____ Date____________

PLEASE LET US KNOW HOW YOU HEARD ABOUT OUR PRACTICE:

___Yellow Pages ___Internet ___Insurance ___Angie's List ____________Family/Friend
____________Other