Kuy, E. Ky, DDS

General Dentistry & Dental Implants

Our philosophy is to provide you the highest quality of patient education and dental care to all our patients. To ensure that you begin with a positive experience we have prepared the following information for you to review.

OFFICE POLICIES

EXPECTED PAYMENT: In order to keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile.

DENTAL INSURANCE: We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request you familiarize yourself with your insurance benefits, and provide us with correct information. Please remember that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee any estimated coverage. Not all services are covered benefits, therefore you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is regardless of your dental insurance benefits, deductible, limitations, or maximums.

PAST DUE BALANCES: Payment for any past due balance is required to be paid in full before incurring new charges. All balances over 60 days are subject to a finance charge.

CANCELLATION NOTICE: If you are unable to keep your appointment that has been reserved for you, we request you provide us with 24 hours advance notice. We realize that emergencies do occur and we will be flexible under those circumstances. Failed appointments are subject to a fee.

INFORMATION CHANGES: To ensure our records are current, please notify us of any changes related to your medical history, telephone numbers, address, employer or insurance information as they occur.

My signature indicates that I understand the policies outlined and any questions I have regards to the office policies have been answered.

_____ _____

Signature of Patient or Responsible Party Date

SIGNATURE RELEASE STATEMENT

I authorize the release of ll medical information necessary to process my claims and I authorize the release of this same information, when necessary, to other providers rendering medical/dental care. I assign all medical and surgical benefits which I am entitled, to Dr. Kuy E. Ky. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Signature of Patient or Responsible Party Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND DENTAL MATERIAL FACT SHEET

I, _____, acknowledge that I have received a copy of the office's Notice of Privacy Practices and Dental Materials Fact Sheet.

_____ _____

Signature of Patient or Responsible Party Date