



## *Welcome to our practice!*

On behalf of all my staff, I welcome you to our office. We are pleased that you have selected us to care for your dental needs and we look forward to your initial visit. We pride ourselves on making your visit a pleasant experience, while providing you with quality dental treatment.

Our emphasis is on early preventive care; however, we also provide restorative care, including full mouth rehabilitation and emergency services. Our primary goal, whenever possible, is the retention of your healthy, natural teeth.

During your first visit to our office, we normally complete a comprehensive examination. This exam will include a medical and dental history review, necessary radiographs and possibly dental impressions. The comprehensive exam allows us to best diagnose your dental condition with respect to your overall health.

Enclosed you will find additional information about our practice. Our patient registration, medical history questionnaire, HIPAA form and financial policies are all included. Please complete these forms at your convenience and bring them with you to your first visit. If you have dental insurance which distributes dental cards and/or a dental benefit booklet, please bring these items to your initial appointment. If a card is not available please have all insurance information, such as provider name, address, and subscriber identification number.

Should you have any questions about our practice, services, or policies please do not hesitate to call our office at (315) 265-5344 or visit our website at [www.drhowlett.com](http://www.drhowlett.com) . We look forward your visit.

Sincerely,

*Stacey M. Howlett, DDS*

## **Financial Information**

*“In God We Trust – All Others Must Pay Cash”*

1. We can be *GOOD*, we can be *FAST* or we can be *CHEAP* – but unfortunately, not all at the same time. Our fees for professional dental services are a reflection of the time, staff, materials, equipment, and current expertise involved in providing you with the very best quality and most personalized dental care possible. We strive to make good dental health affordable for all of our clientele while maintaining a practice that will be here to serve you and our community for many, many years.
2. All major treatment and treatment involving outside laboratory expenses will require a down payment of 1/2 of the total balance before treatment begins, with the total balance paid before any crown or denture is completed.
3. In the case of minor children, the parent or legal guardian authorizing treatment for the child is financially responsible to this office, *regardless of any separation, divorce or court agreements*. We are not a party to these agreements.
4. **Unpaid balances over 30 days will be assessed a 1.5% late charge.** All outstanding balances over 90 days *without prior arrangements* will be subject to collection by an outside agency, which may incur additional fees and adversely affect your credit rating.
5. Returned checks will be assessed a \$35.00 charge to cover bank fees incurred as a result.
6. **We understand that unexpected circumstances can sometimes delay financial obligations. Please contact our office manager immediately to make satisfactory payment arrangements. When communication and good faith exists, we can work it out.**
7. If you have dental insurance, we will help you to determine the benefit that you have available and how it applies to your dental treatment. However, your dental insurance policy is a contract negotiated between you, your employer and your insurance company *only*. We are not a party to that contract.
8. Not all dental insurance plans are created equally. Dental benefit plans vary widely between different insurance companies. Additionally, an insurance company may offer multiple dental benefit plans. And lastly, employees at the same company may receive different levels of benefits based on their job position or years of employment. All recommended dental services may *not* be covered by the plan chosen by you and/or your employer. Please be aware of your plans specific benefits and limitations, and how they may apply to your recommended dental treatment plan.
9. Payment for all services rendered is the financial responsibility of the patient *regardless* of any insurance involved.

# Payment Options

We strive to offer convenient payment plan options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. Before we begin your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices.

Please take a moment to review the financial options offered and indicate your choice of payment.

**Plan A: Payment in full, via Cash, Check or Credit Card, on the day of each visit.**

To show our appreciation for patients who pay in full, via cash or check, at time of service, we will extend a five percent (5%) courtesy fee reduction.

To show our appreciation for patients who pay in full, via Credit or Debit Card, at the time of service, we will extend a three percent (3%) courtesy fee reduction. We gladly accept MasterCard or Visa.

**Plan B: Extended monthly payment plan through Capital One.**

We are pleased to offer a Dental Fee Plan through Capital One. Interest-free options are available for up to 12 months. Low-interest payment plans up to 60 months are also available. For additional information please see the brochure or visit [www.capitalonehealthcarefinance.com](http://www.capitalonehealthcarefinance.com).

**Plan C: Use Medicaid, Child Health Plus or Family Health Plus benefits.**

Our office will file your Medicaid, Child Health Plus or Family Health Plus claims. You are responsible to ensure your eligibility on the date of service. You will be financially responsible for any dental services accepted while ineligible. If a recommended or elective dental procedure is denied through your insurance program you may still choose to have the treatment completed; however, you will be personally responsible for payment at time of service.

**Plan D: Maximize dental insurance benefits, paying 20% Co-Pay at time of service.**

*\*Note: Not available to Delta Dental or GHI policy holders, insurance reimburses subscriber directly.*  
As a courtesy, we are happy to bill your dental plan for completed services. Please remember that your dental benefits contract is between you, your employer, and your insurance carrier. Regardless of coverage, *we estimate a 20% co-pay due at time of service.* If your dental plan does not pay within 60 days of treatment, you must pay outstanding balance and seek reimbursement from the insurance carrier. If your dental plan pays more than expected, you will receive a refund check.

**Plan E: Maximize dental insurance benefits, no Co-Pay, charge Credit Card upon payment.**

*\*Note: Not available to Delta Dental or GHI policy holders, insurance reimburses subscriber directly.*  
As a courtesy, we are happy to bill your dental plan for completed services. Please remember that your dental benefits contract is between you, your employer, and your insurance carrier. *Upon receiving payment from insurance carrier, our office will charge your credit card any remaining balance from the claim.* Credit card numbers will be kept confidential.

MasterCard/Visa Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Signature Code: \_\_\_\_\_ (3 digits on back of card)

Please contact our office if you have any questions regarding the payment options described above.

I, \_\_\_\_\_, have chosen Plan \_\_\_\_\_ (above) and accept full financial responsibility for this account and for all dentistry performed upon my dependents in this dental office. I understand that it is my responsibility to confirm my insurance eligibility and benefits. I know that any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

STACEY M. HOWLETT, D.D.S., P.C.  
1 RIVERVIEW DRIVE  
POTSDAM, NEW YORK 13676  
CONTACT PERSON: AMBER MONTGOMERY

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have read/received a copy of Notice of Privacy Practices for the office of Dr. Stacey Howlett.

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Please Print Name

Patient, Parent or Guardian Signature

Date

**AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION**

Patient Name \_\_\_\_\_

I authorize the professional office of my dentist named above to release health information identifying me (including, if applicable, information about HIV and AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:
2. To whom may the information be released [name(s) or class(es) of recipients]:
3. The purpose(s) for the release (if authorization is initiated by the individual, it is permissible to state "at the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked. Send this note to the office contact person listed at the top of this form.

When your health information is disclosed, as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

**I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM. I ALSO HERBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE DOCTOR.**

Dated \_\_\_\_\_ Patient Signature \_\_\_\_\_

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient \_\_\_\_\_ Print Name \_\_\_\_\_

Source of Authority \_\_\_\_\_