**Jian Huang, DDS, MAGD**
**2810-B Bransford Ave**
**Nashville, TN 37204**

**Office (615)297-8470**
**Fax (615)297-8460**

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### Financial Policy, Fees and Payment Agreement:

We sincerely appreciate the opportunity to have you as our patient. We will give you an estimation of fees for the surgical treatment you need at the time of your initial consultation. Our fees are established from what is considered to be routine and would only change if unforeseen difficulties are encountered during the procedure.

**Please choose one of the following payment options:**
(Please initial your payment option choice in the space provided)

**Option A-** Payment in full at time of service
________ **We accept electronic check, cash, Visa MasterCard and Discover cards.**
________ **We also offer Care Credit with either no interest or low interest Pymt Plans.**

**Option B-** Insurances

________ **Delta Dental Insurance Premier and PPO**
________ **Blue Cross & Blue Shield Dental Insurance**
________ **Blue Cross & Blue Shield Medical Insurance**
________ **Met-Life Dental Insurance**
________ **Cigna Dental Insurance**
________ **United Concordia Insurance**
________ **Tenn Care (TennDent) Dental Insurance (under age 21 ONLY)**
________ **DenteMax Insurance**
________ **Other Insurance** ____________________________________________

**PLEASE READ:**
Insurance companies rarely reimburse the FULL amount of the actual cost of the treatment. Our office quotes current fees that are within the usual and customary range of other Oral Surgeons in OUR area. Many insurance companies determine benefits from a set fee schedule that is extremely out dated. For this reason, our office does NOT participate in Managed Care or PPO programs with the exception of the ones listed above. **I UNDERSTAND THAT IT IS MY RESPONSIABLILTIY TO PAY ANY DEDUCTABLE AMOUNT, CO-INSURANCE OR ANY OTHER BALANCE NOT PAID FOR BY MY INSURANCE. I UNDERSTAND MY INSURANCE COMPANY CANNOT GUARANTEE PAYMENT UNTIL THEY HAVE RECEIVED AND REVIEWED THE CLAIM AND DETERMINED THAT IT IS A COVERED BENEFIT AND/OR MEDICALLY NECESSARY.** You will be responsible for ALL collection costs, attorney's fees, and court cost or any unpaid balance after 60 days. Balances past 60 days will be charged interest at the rate of 1.5% monthly (18% APR).

**Authorization to pay Jian Huang, DDS**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment directly to the dentist named of the insurance benefits otherwise payable to me. Additionally, you acknowledge ALL checks are processed through Electronic Funds Transfer (EFT).
**I agree to the financial plan I have selected above and will be responsible for all fees for treatment not covered by my insurance company.**

► ________________________________________________ ► ____________
Signature of Guarantor | Print Name | Date

### HIPPA Authorization & Release

I, ► ____________________________ give permission to release health/medical/account information to the following persons:
Patients Name
____________________________ Name and Relationship
____________________________ Name and Relationship

HIPPA Authorization for Appointment confirmation:
I, ► ____________________________, give permission for confirmation of future appointments to be left by phone to any recipient who
Patients Name
answers including answering machine and/or voice mail. YES ______________ (Initial) NO ________________ (Initial)

**Acknowledgement of Receipt of Privacy Notice:**
**I acknowledge that I have been provided the opportunity to review a copy of Jian Huang's Privacy Notice.**
►
________________________________________________ ► ____________
**Patient (or) Personal Representative Signature** | **Printed Name** | **Date**