



**SAPPHIRE**  
DENTAL  
PLLC

Your understanding of our financial policies is an essential element of your care and treatment.

Our office policy requires that your bill (or **estimated** insurance co-payment) be paid **at the time treatment is rendered**. Please be advised that **insurance companies do not determine our fees**. We will be happy to help you **estimate** your co-payment based on the information provided to us by your insurance company, and we will file your claim for you. **We cannot guarantee that your insurance company will pay any or all of your charges**. In the event that your insurance company pays you directly, we ask that you pay for your visit in full and be reimbursed by your insurance company. We will accept **Cash, Check, Visa, MasterCard, Discover, American Express and Care Credit**. A courtesy 5% discount may be given for pre-payment in full 3 days prior to appointment for treatment of \$500.00 or more if paid by check or cash.

In all cases, balances remaining after insurance has paid will be billed to the patient. If you have any questions, please discuss them with our office staff. Charges not paid within 30 days will have a service charge of 1.0% (annual rate), or a minimum of \$1.00 added to the past due balance.

**I understand that I am ultimately responsible for the entire fee and agree to be responsible for any charges not paid by my insurance company.** Collection fees will apply to accounts that are sent to collections. By signing below I agree to pay any and all collection fees and attorney fees that would be incurred if my account were to be removed for collection.

This signature is my authorization for the release of information necessary to process my claim and for release of payment of any insurance benefits to Sapphire Dental PLLC.

\_\_\_\_\_  
Patient Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient/Guardian: \_\_\_\_\_

**Heather Neal Blanchard DDS**  
Creating Beautiful Smiles  
**Receipt of Statement of Privacy Practices**  
**Acknowledgment of**

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Heather Neal Blanchard DDS, PLLC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Dr. Heather Neal Blanchard DDS, PLLC reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

**Additional Disclosure Authority**

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

\*Any Member of My Immediate Family \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Spouse Only \_\_\_\_\_ Yes \_\_\_\_\_ No

\*Other: \_\_\_\_\_ Yes \_\_\_\_\_ No

\_\_\_\_\_  
Patient's Name \_\_\_\_\_ Date \_\_\_\_\_