CRESCENT LAKE
FAMILY DENTISTRY
DAMIAN L. CULLOM D.D.S.

FINANCIAL POLICY

FOR ALL PATIENTS: Dr. Cullom requires payment in full for your share of dental fees at the time of service. We accept all major credit cards, cash, checks and Care Credit. We accept Care Credit repayment terms of 6 and 12 months.

PRIMARY INSURANCE: We are happy to file your primary insurance claim for you. Your dental benefits are based on a legal contract between you and your insurance company and/or employer. If you have any questions regarding your benefits please contact your insurance representative to discuss in detail. We do our best to obtain a written and verbal breakdown of your benefits. But there are times when insurance companies provide us with incorrect information or refuse to provide us with a breakdown of your benefits. Therefore, the amount of your insurance benefit is an estimate only. If your insurance company doesn't pay our office in full for the procedure(s) you are responsible for the balance.

SECONDARY INSURANCE: If you have supplementary insurance you must pay your dental fees in full at the time of visit. After we file your primary insurance claim, your insurance company will send you a check along with a statement of benefits. The policy holder will be responsible for sending a copy of the first claim to their secondary insurance company for payment.

CONSENT FOR SERVICES

You have the right to accept or reject dental treatment recommended by Dr. Cullom. As with all surgery, there are commonly known risks and potential complications associated with dental treatment. Even though many of these complications are rare, they can happen. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment until you discuss potential benefits, risks, and complications with Dr. Cullom and all your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

HIPAA PRIVACY RIGHTS AND CONSENT

IMPORTANT: In addition to those mentioned in our HIPAA packet you received, (insurance companies, specialists, primary care doctors etc.), I agree to release my protected information (treatment options, health and dental information, appointments, balances, etc.) to the following individuals: (example: spouse, parents, caretakers, siblings etc.)

Name_____ Relationship_____

Name_____ Relationship_____

Name_____ Relationship_____

By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. It also confirms that you have received a copy of our Notice of HIPPA Privacy Practices and agree to all terms and conditions herein.

Signature _____ Date _____

2135 Dr. Martin Luther King Jr. St. N, St. Petersburg, FL 33704