

Financial Information, Understanding and Agreement

Patients without Insurance: (Self Pay) If you do not have insurance, payment in full is expected at the time of treatment. If you have difficulty with paying the balance, please arrange for a payment option. (See Payment Options sheet).

Patients with Insurance: Your insurance is a contract between you and your insurance company. Knowing your insurance plan is your responsibility. We have a form that you can use to acquire information from your insurance company. (See Insurance Information sheet). Sometimes this information is in an employee packet from your employer or you may have to call the number on your insurance card to discuss your coverage with a representative. We will be glad to discuss any insurance questions you have, but we need information first.

As a courtesy, we will file your insurance claim for you. All dental plans are not the same and do not cover the same services or amounts. For preventive treatment (cleanings, exams and x-rays), the insurance company pays their portion to our office and then the remaining balance is immediately due and payable by you. For all other treatment (fillings, crown, etc.), the co-payment must be paid on the day of service. In the event that your dental plan determines a service is "not covered", you will be responsible for the complete fee. As a further courtesy, we will be glad to send in a pre-determination to your insurance company, prior to treatment, to estimate what your insurance will pay and what your estimated portion will be. However, be aware that your insurance company may not honor their pre-determination estimate. Therefore, you still may be responsible for the entire treatment cost, despite what the insurance company stated they would pay.

Patients with Medicare: If you have Medicare coverage, please inform us. You will need to complete an Opt Out Form. If you have Part D prescription plan, your prescriptions should be covered per your policy. If you have the Advantage plan, your prescriptions may not be covered. We do not accept Medicare dental payments and you will be responsible for the full payment of treatment. Please ask if you need additional information regarding Medicare coverage.

Minor Patients: Please indicate, by signing below, who will be the responsible party for the payments for a minor child. If this is not completed, we will assume the person bringing the patient to the initial appointment will be responsible for the payments.

Divorce and Child Custody Decrees: Resolution for payment must be handled between the parties involved and our office cannot be a go between for domestic arrangements.

Cancellation and No Shows: If unable to keep an appointment, kindly give 24-hour notice. Otherwise we reserve the right to charge \$50 to the account for the time reserved for the appointment.

Financial Policies if Balance Not Paid in Full

We will make every effort to work with you for payment options. However, sometimes things happen that unfortunately have to be addressed.

For returned checks, a \$25 returned check fee will be accessed to your account.

If 60 days have elapsed and we have not received any payment from you and/or you have not contacted our office regarding your balance, there will be a minimum \$5 late fee accessed to your balance (accrued on a monthly basis). This fee is subject to change pending the amount owed and time since last payment.

Accounts that are 90 days past due (without any payments made and/or no contact from you regarding your account) will be subject to the following actions:

- 1.) Account may be sent to Collection Agency: Collection fees of approximately 25% of the account balance will be added to the account when it is turned over to the collection agency.
- 2.) Account may be sent to Small Claims Court: The responsible party will pay all court costs associated with collecting for services rendered.

If you receive a notice that the account is going to any of the above places, you still have one last chance to stop the proceedings by calling us and working with us to resolve the issue.

I have read and understand the above policies and agree to abide by them.

Patient Name (print)

Date

Signature of person responsible for account payment

Print name of person responsible for account payment