OFFICE FINANCIAL AND INSURANCE POLICY

In order to provide dental service for our patients, it is necessary that you understand and agree to our insurance, credit and collection policies. Your dental insurance policy is an agreement between you and your insurance company. In contrast, an agreement to perform treatment (services) is an agreement between you and our office. **When you have services performed, you become responsible for payment of our fees associated with the services provided to you.** Your dental insurance company may provide coverage for a portion of the services provided, thereby reducing the amount of the fee paid by you. Coverage for services and levels of benefit payments by your insurance company depend on the terms of the contract between the insurance company and you. It is your responsibility to understand the terms of your dental insurance plan, including but not limited to: deductibles, co-payments, benefits, limitations of coverage, excluded services and annual benefit maximums. X_____

Verification of Coverage/Benefits: It is your responsibility to provide our office with current insurance plan information. This will allow us to properly electronically file dental claims so that allowable benefits are paid by your insurance company for services provided. Please familiarize yourself with your plan and confirm that it is active at the time of your dental services.

X_____

Deductibles: A deductible is the amount of covered dental expenses that must be paid by a patient before an insurance company will begin to pay benefits. Examples of a standard deductible are $25 or $50 per person and/or family per calendar year. The deductible may not apply to all dental services. **You are responsible for full payment of deductibles at the time services are provided.** X_____

Co-Payments: A co-payment is a share of covered dental costs that the patient pays and is stipulated by the terms of the dental insurance policy. In other words, co-payment is a defined percentage of a covered service, for example 20% or 50%. Our office will provide our best estimate of your co-payment for each visit. **Our office policy requires payment of patient co-payments at the time services are rendered.** X_____

Usual, Customary & Reasonable (UCR): Your insurance carrier establishes its own payment schedule for dental services. Each insurance carrier sets its own reasonable and customary fee schedule. Benefits paid by the carrier are paid as a percentage of its reasonable and customary. The UCR varies from carrier to carrier. Insurance carriers do not negotiate their reasonable and customary fee schedule with dental offices. An insurance carrier's reasonable and customary is not the same as an office fee.

Pre-determination of Benefits: As a courtesy to you, our office will complete a pre-determination of benefits to help you understand your potential insurance benefits. A pre-determination of benefits is an **estimate** of benefits your insurance carrier may pay and your corresponding co-payment. It **is not a guarantee** of payment. Pre-determinations typically expire after one year and may not be honored by the insurance carrier. In the event you delay treatment, an administrative fee of $35 must be paid, if you request that our office complete a new pre-determination of benefits. X_____

Forms of Payment: Our office accepts the following methods of payment: Cash, Money Order, Personal Check, Visa, Mastercard and Discover. Our office **does not** accept American Express for payment. For your convenience, our office also offers financing through Care Credit. If you are interested in Care Credit, you may request further information. X_____

Payment Terms: Deductibles and co-payments are due at the time services are rendered, **without exception**. No further appointments will be scheduled if an account is past due. Past due accounts will incur a monthly service charge of $25 and 1.75% interest monthly. There is a returned check fee of $25. X_____

Broken Appointments: If you need to change your scheduled appointment, our office requires that you contact us 48 hours prior to reschedule. Broken appointments will incur the following fees: non-surgical appointment $35, surgical appointment $135.

X_____

Signature of patient:_____ Date:_____

(If patient is 18 years or older, his/her signature is required in addition to the "responsible party.")

Signature of Responsible Party (if other than patient):_____ Date:_____