Office Financial Policy

We share your concerns regarding the increasing cost of health care. We believe that you, our patients expect and deserve the highest quality care we provide at a reasonable cost. While we take advantage of every possible avenue to keep cost down, we are committed to not sacrificing quality for less expensive care. With this in mind, we would like to share some information with you about our financial policy. We hope you will consult with us if you have any questions regarding out services and our financial policies.

Many people are under the impression that if they have insurance, it is the insurance company who owes the doctor for services. Please keep in mind, the insurance contract is between the patient and the insurance company. **Therefore, the patient is responsible for the bill, regardless of insurance coverage determination. As a courtesy to our patients, we are happy to bill your PRIMARY insurance for you, however, the responsibility for payment remains with the patient (or insured).**

PAYMENT IS EXPECTED AS SERVCIES ARE RENDERED UNLESS PRIOR FINANICAL ARRANGEMENTS HAVE BEEN MADE.

APPOINTMENT CANCELLATION OR 'NO SHOW': As a courtesy, we will contact you 2 working days before to verify your appointment. This provides adequate time to cancel or change your appointment if needed. At least 1 working day (24 hour) notice **is required** to avoid the $50.00 late cancellation or no-show charge. This charge is not billable to any insurance carrier.

PATIENT RESPONSIBILITY: (a) I understand that a deposit of at least 50% is due in order to schedule treatment. **(b)** I understand that I am responsible for any amount not covered by insurance. I agree to provide payment within 30 days of notification by statement of this responsibility. Failure to do so will incur additional billing charges.

PATIENTS WITH INSURANCE: At the time of treatment patients are **REQUIRED** to make an initial treatment deposit toward the **ESTIMATED CHARGES**. If you're insurance pays in addition to the balance due on your account, a refund will be sent to you promptly.

As a courtesy we will assist you in **ESTIMATING** YOUR COVERAGE. The actual amounts of coverage may vary from this **ESTIMATE**. **Many insurance plans state that you will be covered up to "50%, 80%, 100% ". In spite of that statement, we have found in actuality that many plans may cover less than that depending upon their established "usual and customary fees" and what services they actually cover.** Please be aware that some insurance companies will pay a claim percentage based on their **"usual and customary fees,"** not our actual charges. To determine what portion of

your bill will be covered by insurance, we will gladly request a pre-authorization by your carrier; however, this may require up to eight weeks to be processed by the insurance company.

PATIENTS WITHOUT INSURANCE: Patients without insurance are required to make full payment at the time of treatment.

CHARGE CARDS: Visa, MasterCard, American Express, Discover, may be used for payment.

PATIENT FINANCING: We participate in Care Credit that allows patients to finance their treatment through this third party lender. If you are interested in this service, please ask the business manager.

RETURNED CHECKS: There will be a $25.00 charge for all returned checks. Returned checks may also be forwarded to our collection agency for further action.

If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance including, but not limited to collection agency fees, attorney's fees, filing fees, and court costs when necessary, will be added to the balance referred. If your account is placed with a collection agency, we will terminate the availability of our services to you and you will be dismissed from the practice.

AGREEMENT: I have read and understand the financial policy of the practice and I agree to be bound by its term.

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Signature of Patient, Parent or Legal Guardian Date