FINANCIAL POLICY and INSURANCE GUIDELINES

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care your family deserves.

- If you have dental insurance, we will assist you with your benefit eligibility **before treatment** to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help your children achieve the best oral health possible. Ultimately, however, you are responsible for payment regardless of any insurance companies' arbitrary determination of usual and customary rates. _____
- While we accept all dental insurance plans, we are only considered in-network with Dental Care Plus and Delta Dental Premiere**. Anthem Blue Cross and Blue Shield and Superior Dental members: <u>Payment will be due in full on the day of service.</u>** *Being out of network does not mean you do not receive benefits.* We strive to help you make optimal use of your dental insurance and as a courtesy to our patients, we are happy to file your primary dental insurance claims. Our office does not file secondary insurance claims due to the lengthy time commitment and delay in payment on services rendered. _____
- Your insurance policy is an agreement between you and the insurance company; we ask that all patients be directly responsible for all charges. Your estimated co-payment will be due at the time of service, however we cannot guarantee any estimated coverage. You will be expected to pay for services in full if this office is unable to verify your plan information before treatment. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. _____
- If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for your treatment is considered due and must be collected. Office Policy is to charge 1.5% monthly fee with the minimum $2.00 to all accounts that are over 60 days past due. Delinquent balances over 90 days old will be transferred to a collection agency. The fee accessed for this transfer and administrative expenses is $30.00. Any fees incurred from the collection agency and attorney employed will be passed on to you. Further appointments will not be scheduled until all balances and fees are paid in full. Future appointments will be on a cash only basis. _____
- We accept the following forms of payment: Cash, Check, American Express, Visa and MasterCard. We offer a 7% discount for all treatment paid in cash or check on the day of service. This discount is reserved for cash patients without insurance benefits. In addition, we offer Care Credit, a patient payment program offering a full range of Deferred Interest and Extended Payment Plans for treatment. _____
- Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office. Your check will be retained by our office until a full cash payment is received. _____
- Separated or divorced parents of minors, who are responsible for one half of the cost of a child's/children's dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. If it is necessary, we are happy to hold a credit/debit number from the non-custodial parent on file. _____
- We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have. _____

I have read and agree to the Financial Policy and Insurance Guidelines.

Signature of Patient or Responsible Party: _____ Date:_____

Print Patient(s) Name:_____