Financial Policies and Information

PLEASE READ CAREFULLY

Our commitment is to provide the very best care to you, our patient. Your clear understanding of- and agreement to- our financial policies concerning your dental care is fundamental to our professional relationship with you. Should you have additional questions about our fees and financial policies, or about your responsibilities relating to your insurance coverage, please contact the Practice Manager.

PROFESSIONAL FEES: Our prices are representative of the usual and customary charges for our area. Our fees reflect the Provider's time dedicated to your care. That time includes the review of any prior records, diagnostic testing, authorizations and other insurance requirements as well as the coordination of your care with other physicians involved in your health care planning.

INSURANCE PAYMENTS: We participate in assignment of payment with specific insurance plans. **Your insurance coverage is a contract between you and your insurance plan.** It is your responsibility to verify and know your insurance benefit coverage including your out-of-pocket requirements. If your insurance plan is one with which we participate and if you have provided valid proof of insurance for that plan, we will submit your claim(s) as a courtesy to you, our patient.

PROOF OF INSURANCE: Before being seen by a Provider, you must complete the Patient Information Form; provide a driver's license or legal identification card; and, provide a current valid insurance card as proof of insurance. If the insurance information you provide is incorrect, you will be responsible for the balance of the claim.

PATIENT PAYMENTS/SELF-PAY BALANCES: **Your co-payments and deductibles, services not covered by your insurance plan, and, self- pay balances are due at the time of your appointment.** Your balances are due upon receipt of the statement unless you have made other arrangements prior to the service being rendered. You may pay by cash, check or credit card. We accept Visa, MasterCard, Discover and American Express. **After 90 days of non-payment, a late fee charge of $10.00 per month will be added to your account and your account may be turned over to a collection agency.**

APPOINTMENTS: Please understand that your appointment is time that has been reserved for your health care needs. If you need to cancel your office and/or procedure appointment, we require a 2 business day notice. Please call us 48- hours in advance. **If you fail to give the proper notice or fail to show up for a scheduled office appointment, you will be assessed a $50 No Show fee that will be due before your next office visit.**

NON-COVERED SERVICES: Some services you receive may be non-covered or may be considered not necessary by your insurer. You must pay for these services in full at the time of your visit. Insurance carriers will sometimes limit coverage of certain services based on the diagnosis or the frequency in which they are performed. In the event that your provider identifies the potential for denial of your claim for either of these reasons, you will be provided with the expected cost to you for the services prior to services being rendered. You will be able to elect to receive the services and be responsible for the cost or elect to decline the services.

COLLECTION AGENCIES: If it becomes necessary to place your account with a third-party collection agency due to non-payment, you may be discharged from our Practice. Should this occur, we will treat you on an emergency basis only for the next 30 days while you find alternative care.

BOUNCED CHECKS: A $50 charge will be applied for each check returned by your bank. If you have had more than one bounced check, your Provider may elect to not accept future checks from you.

YOUR SIGNATURE ON THIS PAGE CONSTITUTES AN AGREEMENT TO THIS POLICY.

I have read and agree to the above Financial Policies and Information. I hereby assign all dental benefits to which I am entitled through my insurance - governmental or private - to Mid Bay Dental. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

Name of Patient: _____ Date: _____

Signature of Patient/Parent/Guardian: _____