Myersville Dental
Kenneth A. Film, DDS
301-293-3456
301-293-3566 (fax)

Financial Policy

effective 9-1-2009

3039 Ventrie Ct, Ste E
PO Box 270
Myersville, MD 21773
info@myersvilledental.com

This is an agreement between Myersville Dental/Kenneth A. Film, DDS, as creditor, and the Patient or Responsible Party named on this form, as debtor.

In this agreement the words "you," "your," and "yours" mean the Patient or Responsible Party. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Myersville Dental and Kenneth A. Film, DDS

By executing this agreement, you are agreeing to pay for all services that are received for yourself or the dependent listed as the patient on this form.

Missed Appointments & Cancellations: The second time a patient does not show up on time for an appointment or cancels with less than 2 business days notice, a $50 Missed Appointment & Cancellation fee will be charged. Business days are Monday, Tuesday, Wednesday, and Thursday. Please note that Friday, Saturday, and Sunday are not business days. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

Non-contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Monthly Statement: If you have a balance on your account, we will send a monthly statement. It will show the previous balance, any new charges to the account, and any payments/credits applied to your account during the month.

Payments: Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 30 days of the statement date.

Payment options if you have no insurance:

1. You must pay the full treatment total, by cash, check, or credit card, on the day that treatment is rendered.
2. On extensive treatment, you may prefer to secure third party financing for the entire amount and make payments to the lending institution.
3. We offer special financing through CareCredit. CareCredit offers no- or low-interest payment plans. Information is available at www.carecredit.com or by contacting our financial coordinator.
4. We may offer you an automatic payment plan, at our discretion.

Payment options if you have insurance:

1. You must pay, by cash, check, or credit card, your deductible and any out-of-pocket estimates at the time services are rendered.
2. You may opt to pay all of your treatment by cash, check, or credit card and we will request your insurance carrier send their payment directly to you.
3. On extensive treatment, you may prefer to secure third party financing for the entire amount and make payments to the lending institution.
4. We offer special financing through CareCredit. CareCredit offers no- or low-interest payment plans. Information is available at www.carecredit.com or by contacting our financial coordinator.
5. We may offer you automatic payment plans, at our discretion.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would need to be paid at the time of service.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned checks: There is a $10 fee, subject to change, for any checks or automatic payments returned by the bank.

Past due accounts: If your account becomes past due (more than 30 days past the statement date), we will take necessary steps to collect this debt. This may include reporting your account to a credit bureau for inclusion in your credit report, referring your account to a collection agency, and/or taking legal action, If we have to refer your account to a collection agency, you agree to pay all collection costs incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees incurred plus all court costs. In case of suit, you agree the venue shall be in Frederick County, Maryland.

This Financial Policy continues on the back of this page.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for payment of the account, unless a new Financial Policy is signed. For new accounts involving previously divorced individuals, the parent authorizing treatment for the child will be the parent responsible for payment of charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility pay for the treatment received and to collect from the other parent. We will only send statements to the authorizing parent.

Transferring of Records: You will need to submit a written request if you want to have copies of your records sent to another doctor or organization. We have the right to charge for copying your records. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your dental insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: ____

Responsible Party (if not the patient): ____

Responsible Party Signature: ____ Date: ____________

Co-Signature: ____ Date: ______________