

FINANCIAL AND INSURANCE POLICY

Thank you for selecting us to be your dental health care provider. My staff and I are committed to your treatment being a positive experience. Please understand that your financial obligations are considered part of your treatment as well. The following is a statement of our financial and insurance policies.

CASH ACCOUNTS: (those accounts without the benefit of dental insurance.) Payment is due in full the day services are rendered. We accept:

- Cash
- Check (returned check fee of \$35.00-immediate remittance in the form of cash, money order or credit card is required on all checks that are returned to our office.)
- Visa, MasterCard, and Discover.
- Extended Payment Plan (***with prior credit approval***) through CareCredit or Citi HealthCard-a medical/dental credit card with many no and low interest financing options.

INSURANCE ACCOUNTS:

- Patients with dental insurance are required to pay their deductible and copayments at the time treatment is rendered.
- If your insurance card is not presented, or if we are unable to verify your dental insurance coverage, full payment is due at the time service is provided.
- While filing insurance claims are a courtesy we extend to our patients, we must emphasize that as dental providers, our relationship is with our patients and not the insurance company. In the state of Maryland, insurance companies are required to pay claims within 30 days. If payment is not received from your insurance company within 60 days, the total balance will become your responsibility.
- Our practice is committed to providing the best treatment for you at a fee that is reasonable and customary for this area. Not all insurance companies reimburse based on a fee schedule that is current and standard *for this area*. Therefore, you are responsible for payment regardless of any insurance company's arbitrary determination of reasonable and customary.

MINOR PATIENTS

Minors must be accompanied by a parent or guardian for all appointments. The parent is required to stay in the office while child is being treated. The adult accompanying the minor is responsible for full payment.

CANCELLED OR MISSED APPOINTMENTS

Your scheduled appointment time has been reserved for you at your request. Please help us serve you better by keeping your scheduled appointment. If the time becomes inconvenient for you, please notify our office. Cancellations with less than 24 hours notice or missed appointments will result in a fee of \$60.00 being charged to your account. It is not our intention to charge you, however, we do require notification in order to offer that time to another patient in need of dental care.

PAST DUE ACCOUNTS

Any account overdue more than 60 days will incur a monthly billing charge of \$3.00. Any account overdue more than 90 days will be turned over to a collection agency and subject to additional fees, including but not limited to, collection and legal fees, court costs, etc.

I have read the policies listed above and agree to accept and abide by those policies. I understand that I am responsible for all financial responsibilities for services rendered.

Signed: _____ Date _____
(Patient or Parent/Guardian of minor)

