

**CATHERINE A. HA, DMD, PA
CAROLINA DENTAL ASSOCIATES**

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This is an agreement between the Doctor, as a creditor, and the Patient/Debtor/Guarantor named on this form.

In this agreement the words “you”, “your” and “yours” mean the Patient/Debtor/Guarantor. 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” or “our” refer to the Doctor.

By executing this agreement, you are agreeing to pay for all services that are received.

We strive to be a statement-less office. If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, the finance charge (if any), and any payments or credits applied to your account.

PAYMENT POLICY

If you need dental treatment, the doctor performing your exam will create a written treatment plan for you. Our financial/insurance coordinator will review your treatment plan and inform you what your estimated financial responsibilities are prior to scheduling for those dental procedures.

We accept cash, personal check, money order, debit cards, Amex, Discover, MasterCard or Visa cards upon your arrival on the treatment day. You may be asked to pay a deposit to reserve your appointment time. Any patient arriving without your co-pay may be asked to reschedule.

We have several reputable 3rd party financial companies that can handle long term financial for those who are interested. Please feel free to contact our financial coordinator for further details.

INSURANCE POLICY

Dental insurance is a contract between you and your insurance company. We are **NOT** a party to this contract, in most cases. We will bill your primary insurance 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. Please bring your insurance card with you so we may do a complimentary benefits check for you. You agree to pay any portion of the charges not covered by your insurance.

If your insurance is a DMO (Dental Maintenance Organization), please make sure you are assigned to our office.

For extensive procedures, a pre-authorization or pre-estimate to your insurance may be sent at your or our discretion. It will take at least two weeks to receive an answer back from your insurance.

We do not bill to your secondary insurance company. For each date of service, we will file your primary insurance once. After 30 days from the date of service and we have not received payment from your insurance company, you will be required to pay the full balance and seek reimbursement from your insurance company.

COMPOSITE RESINS (“TOOTH-COLORED FILLINGS”)

We are an amalgam (mercury) free office. If your insurance only pays for the alternate amalgam fee, then you are responsible for the non-covered difference in the fee.

FINANCE CHARGES: A finance charge of 18% a.p.r. (or 1.5% per month) may be imposed on each item of your account which has not been paid within the required due date on your statement.

MISSED APPOINTMENT FEE: If you do not show up or cancel your appointment, with less than 24 hours notice without a valid reason, a fee will be charged. Depending on the length of the appointment the fee can range from \$75-125. This fee must be paid before a new appointment is scheduled. Patients with 2 or more consecutively missed appointments will be asked to transfer their records to another dental office.

PAST DUE ACCOUNTS: If your account becomes delinquent, we will take necessary steps to collect this debt. If we have to refer your account to a third party collection agency, attorney and/or court, you agree to pay the outstanding balance due plus all of the collection agency, attorney and/or court fees.

RETURNED CHECKS: There is a \$30 fee charged to your account for any check returned by the bank. If this occurs, you will be required to pay with cash or money order the balance due plus a \$30 returned check charge.

RECORDS TRANSFER FEE: There is a \$15 fee per person if you would like copies of your records and x-rays transferred to another dental office or to your address. We are legally allowed by State and Federal Law up to 30 days to process this request. This request needs to be made in writing. We will provide you with the Request for Records form to fill out.

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

Guarantor Name: _____

Guarantor Signature: _____

Date: _____