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Financial Policy

Thank you for selecting Dover Family and Cosmetic Dentistry for your dental needs. We are deeply committed to providing you and your family with superior dental services, using state-of-the-art technology in a comfortable and professional environment. We ask that you review and sign this financial policy prior to treatment (this form is also available on our website).
Please feel free ask questions if you do not understand any of these policies.

Insurance Benefits: As a courtesy, we are happy to submit your insurance claim for you to your insurance company. It is imperative you provide us with complete and accurate information. **In the event your insurance information changes, it is your responsibility to provide our office with updated information immediately.**

Your dental insurance is an agreement between yourself and the insurance company; **NOT** between Dover Family and Cosmetic Dentistry and the insurance company. It is important that you fully understand your insurance benefits (i.e. what is covered and not covered, benefit limits, exclusions, missing tooth clauses, etc.). Some or all of the services provided by our office may not be covered by your insurance. **Therefore, you are ultimately responsible for all charges on the account.**

You are responsible for paying your annual deductible as well as providing the estimated balance after the primary insurance payment has been calculated (copayment). We will provide to you the estimated copayment. After we submit the claim and receive the payment from your insurance company, you will be billed for any difference between the anticipated insurance payment from your insurance company and the actual insurance payment. If we receive a payment from you insurance company that is actually higher than the estimation, we will either refund the difference to you or provide a credit onto your account for future services.

Please keep in mind, the copayment that is estimated during each visit is only an estimate; your insurance company makes the final decision regarding the actual copayment amount. If your insurance company pays less than the amount that we estimate, you are responsible for that balance. You must contact your insurance company directly if you have any disputes regarding the payment that was provided to our office.

In the event the insurance company denies a claim, we will review the reason for denial and then submit the claim, if appropriate. If the claim is denied the second time, you are responsible for

providing the payment in full to our office. You may contact your insurance company directly for reimbursement.

Payment is your responsibility: We will issue a statement to you within 30 days of receipt of payment from your insurance company (no more than 60 days from your initial visit). You will have 30 days to pay your balance (unless prior arrangements have been made). In the event your balance is not paid within that time frame, your account will be referred to a collections agency. **If your account is referred to a collections agency, you will be responsible for all fees associated with this process.**

Cancellation and Failed Appointments Policy: If you are unable to attend your scheduled appointment for any reason, you must provide 24 hours advanced notification. This will give our office an opportunity to provide your appointment to another individual. **Failure to provide 24 hour notification to change or cancel a scheduled appointment is subject to a $25.00 cancellation fee and will be automatically added to your account. If you fail to show up for two (2) or more appointments, we may dismiss you from our dental practice.**
If you are late for your appointment, you will be rescheduled and charged the Failed Appointment Fee.
Minor Patients: All patients under the age of 18 must be accompanied by an adult. The adult accompanying the minor is responsible for the full payment for the service provided.

OVERVIEW OF FINANCIAL POLICY

1. **I understand that I am responsible for the copayments and deductibles. I will be provided with an estimate of the copayment amount on the date of service. In the event my insurance company pays less, I will be responsible for the balance.**
2. **I authorize the insurance company to pay the dentist directly for the services rendered.**
3. **I understand a statement will be issued to me if there is a balance on my account. The balance due must be rendered within 30 days. In the event a balance remains beyond 30 days, the collection process will begin and I am responsible for all charges associated with this process.**
4. **I understand it is my responsibility to advise the office of any changes to my insurance and contact information as soon as this change occurs.**
5. **I understand 24 hours notice must be provided to change or cancel an appointment or a cancellation fee of $25.00 may be added to my account.**
6. **I understand two (2) or more failed appointments may result in dismissal from the practice.**

By providing a signature, I am affirming I have read and understand this financial policy.

X_____

Signature Date