

FINANCIAL POLICY

Thank you for choosing R S Family Dental as your dental care provider. Our practice is committed to delivering the best treatment possible for each of our patients. Your clear understanding of our financial policy is important to our professional relationship, and allows us to concentrate on patient care.

We must emphasize that as dental care providers; our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges from the date of service are rendered, are your responsibility. Your insurance is a contract between you, your employer, and your insurance company. We are not a party to that contract .

If you have a dental insurance plan, please remember your co-payment is due at the time of service. This is a requirement of your insurance company. If we do not participate with your insurance company, payment for office visits are due at the time of service. However, we will bill dental procedures to the insurance for you as a courtesy. Please be aware that you will continue to receive statements from us until your account is paid in full. This will alert you that the insurance company has not yet sent payment to us on your behalf. Your insurance company may send the payment to you, the insured, not the Doctor. It is your responsibility to forward both the payment and the accompanying explanation of benefits to our office. This will allow our billing office to post accurate payments and reconcile your account. **We are only “In Network” with Delta Dental Premier plans.**

Canceled Appointments

It is important that you keep your scheduled appointments. If you are unable to do this, please call our office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged \$50.00.

Dependent Children

The responsibility of payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of the practice.

WorkersCompensation / No Fault

Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment from the patient will be expected until the practice is provided with all the information necessary to submit a claim. We realize that temporary financial problems may affect timely payment of your account . If such problems do arise, we encourage you to contact our billing office promptly for assistance in the management of your account. If you have any questions or need any additional information regarding our financial policy, please do not hesitate to call our billing office at (609) 585-1410.

Payment

I hereby authorize and instruct the insurance company(s) noted to pay authorized benefits on my behalf to R S Family Dental. This payment will not exceed my current indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment amount. I also authorize the release of any medical information required to process payment claims.

Initial: _____

FINANCIAL POLICY (CONTINUED)

- * I understand I am financially responsible for payment in full of all charges related to my dental treatment.
- * I understand that my dental insurance carrier or payer of my dental benefits may pay less than the actuarial bill for services.
- * I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part, by my dental or health insurance carrier or dental care payer.
- * I understand that interest of 1.5% per month (18% APR) will be applied to all accounts over 60 days, regardless of insurance involvement. I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on my outstanding balance.
- * There will be a \$35 handling fee for returned checks.
- * No charge will be made for rescheduling an appointment provided 24 hours notice is given. Otherwise, a minimum charge of \$50 will be incurred. Once an appointment has been made, please remember this time has been reserved specifically for you.
- * It is the practice policy to receive payment prior to completion of treatment, for your convenience, we are retaining your credit card on file. We will authorize payment of balance due only after we notify you.

CARD # _____ **SECURITY CODE** _____ **EXPIRATION DATE** _____

NAME ON CARD _____ **SIGNATURE** _____

INSURANCE AUTHORIZATION ** ASSIGNMENT OF BENEFITS **MEDICAL UPDATE

I hereby authorize R S Family Dental Inc. to furnish information to insurance carriers and electronic claims carriers concerning my dental treatment and I hereby assign to the Dentist(s) all payments for dental services rendered to me or my dependents. I understand that I am responsible for any amount not covered by insurance.

I have read and understand the above financial policy:

Patient Name (Print): _____ Parent/Guardian Name (Print) : _____

Signature: _____ Date: _____