Pershing Family Dental Financial Policy

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At **Pershing Family Dental**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some do not. If you have dental benefits, **congratulations!** You are very fortunate. Here are some important things you should know….

I. Submission of Insurance

Patients who carry dental insurance understand that all dental services rendered are charged directly to the patient & that he or she is personally responsible for payment of all services. Pershing Family Dental is happy to submit insurance claims to the insurance company designated as a courtesy. However the patient or responsible party designated is responsible for 100% of fees for services. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. We will be happy to assist with outstanding claims that need to be resolved. However we are not the insurance company & we cannot make the insurance company render payment for services. It is important for you to understand your policy & what benefits are available to you. Dental benefit plans will never pay for the completion of extensive dental care. It is only meant to assist you. Therefore, dental insurance rarely will pay 100% for services rendered. Please expect to pay your estimated portion at the time services are rendered & any remaining balance once insurance pays their portion.

II. Insurance Estimating

We work with hundreds of dental insurance companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE.** In the event that your insurance company pays more then we estimated & the amount is $50.00 or more we can refund that portion to the patient by check via mail. However, if the amount is less then $50.00 the amount will be used as a credit within the practice for services rendered. We are always happy to apply any credits to your account for any unfinished treatment for anyone pertaining to the same account.

III. Insurance Payment in a Timely Manner

We bill your insurance as a courtesy. If insurance does not pay within 60 days, Pershing Family Dental reserves the right to request payment in full from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU** and **your insurance company**. Our office is not, and cannot be a part of that legal contract. Ultimately you are responsible for all charges incurred in our office.

IV. Patient Payment at Time of Service

Pershing Family Dental does require payment in full for your estimated portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks (for existing patients with an established payment history). If you are in need of an extended finance option, we offer financing through Care Credit, who offers a three, six, and twelve month "same as cash" finance option. Care Credit also offers longer terms with interest rates designed to meet your treatment plan needs. All Care Credit payment options are based on approved credit.

V. Responsible Party

It is necessary to distinguish a responsible party for all accounts. In the case of divorced parties where dependents are involved, one parent will be designated as the responsible party and will subsequently take on 100% of the financial responsibility for such dependents. We will bill all

eligible insurance as a courtesy only. All treatment must be authorized through the responsible party. **All adults** are responsible for 100% of their own financial agreements. Any eligible insurance will be billed as a courtesy only.

VI. Collections

Pershing Family Dental will employ a collection agency for all outstanding debt not reconciled within a timely manner. Patient or responsible party agrees to pay all charges, commissions and fees, including any legal or attorney fees, associated with such action.

VII. Communication

Communication is very important in our office and as such we ask that you keep a current phone number and address up to date on our records so we may contact you if necessary. I grant permission to Doctor _____ , or Pershing Family Dental staff to contact me at home or place of business to discuss matters related to this form. I also agree to let this office leave messages on my answering machine or with family members with any questions.

VIII. Release of Information

I authorize release of all identifiable information concerning my account, including charges billed, payments made, interest charges assumed, etc., to Doctor _____ or Pershing Family Dental and any collection agency this practice decides to use. I authorize release of information to insurance carriers to collect on my behalf. I authorize payment to come directly to Doctor _____ _____ or Pershing Family Dental from any or all 3rd party or regular insurance carriers.

IX. Broken Appointments

Missed appointments are very costly and waste valuable time for us and other patients. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least a 24 hour notice to avoid a cancellation fee. A $75.00/hr fee will be charged for the 1st missed appointment, a $100.00/hr fee will be charged for the 2nd missed appointment. If a patient misses a 3rd appointment a $150.00/hr fee will be charged and possible risk termination of Doctor/Patient relationship. We also require a $100 deposit to hold any major treatment appointments. If you do keep your appointment, the $100 will be applied toward your treatment. If you miss your appointment or cancel last minute, the $75 will to go to cover your failed appointment fee.

X. After Hours/Weekend Emergencies

In the event of an emergency after regular business hours a $75.00 emergency fee will be charged to established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged a $125.00 after hours emergency fee.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation/arbitration signed previously related to financial arrangements or quality of care is null and void. I acknowledge that I have received a copy of this office's Privacy Policy (HIPPA agreement). I hereby agree to abide by the conditions outlined herein.

We welcome you to our dental family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits more pleasant, please don't hesitate to ask one of our staff members.

_____ _____

Patient Name (printed) Date

_____ _____

Patient Signature (or guardian or parent if patient is under 18) Staff Initials