



## **FINANCIAL AGREEMENT**

It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatments affordable to all our patients. Please review the following policies and procedures:

\* All patient balances are due immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

\* Should a balance accrue on account a statement will be sent, and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days interest may be applied to the entire account balance. A revised statement with the new account balance, payable immediately, will be sent.

\* A returned check fee may also be applied and must be payable by you for each check payment returned to us by your bank.

\* Dental insurance is a contract between the patient, their employer (if applicable) and the insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, the patient is responsible for any treatment that is unpaid by the insurance provider. If there is dental insurance on the account, the patient must understand that the clinic will have an established patient balance based on the information provided by the patient. Final treatment payment is subject to the terms and conditions of the patient insurance provider on the date of service. As such, until payment is received from the insurance provider, no patient payment is final.

\* Estimates and treatment plans are based upon information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. Please understand that we will provide an insurance estimate to you; however, it is not guaranteed that your insurance will pay exactly as estimated.

\* Estimates do not take into consideration any money that was billed toward financial maximum or treatment limits that may have been used at other dental clinics.

\* A submission to the insurance provider will be sent to determine an approximate cost. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from the insurance provider(s) are NOT a guarantee of payment.

\* As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will try to anticipate any changes in the treatment plan and advise the patient at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

\* The clinic accepts most major insurance plans. However, with the frequent changes that happen in the insurance marketplace, it is the patient's responsibility to contact the insurance company prior to the appointment and verify if we are a participating provider as per your plan.

\* Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, deductibles and maximums which are the patient's responsibility.

\* Full Payment and/or co-payments are due at the time of service. The Patient or guarantor is responsible for all fees and services not covered by the insurance. Balances 30 days overdue will be automatically processed via card on file, outstanding balances will be sent to collection in addition to any late fees. To find out about arranging a payment plan, please speak to our patient coordinator.

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**PAYMENT POLICY:** Payment is due at the time services are rendered. If you have dental insurance, your estimated co-pay plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit. We kindly ask that you provide photo identification and a valid credit card which will be kept on file in your record for payments that need to be made to your account.

1. We accept cash, personal checks with proper ID, money orders, debit cards, Visa, MasterCard, and Discover.
2. If there is a balance and the charges have been on account for over 90 days, you will be required to pay Premier Endodontics LLC an 18% (per annum) finance charge per month on the unpaid balance until paid in full.
3. You will be responsible for all costs incurred in the collection of your debt (i.e. collection agency fees, court fees, and/or attorney fees).
4. Financing is available through Care Credit with prior approval.
5. Fees will apply for any check that is returned by the bank.

**DENTAL INSURANCE:** As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

1. You must provide us with any insurance card and/or all the information necessary to verify your coverage and file your claim.
2. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
3. You are responsible to pay our fees; not what your insurance company allows or considers "usual, customary, and reasonable" (UCR), all of which vary from one company to another.
4. Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of your benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
5. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.
6. Treatment provided in another dental office during your current plan year may alter your co-payment due to services in our office. In such cases we cannot track whether you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.

7. There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We will provide you with the most accurate information available to us but CANNOT guarantee what your out-of-pocket expenses will be.
8. Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations.

**BROKEN OR MISSED APPOINTMENTS:** To reschedule or cancel an appointment, you must notify us at least 48 hours in advance to avoid a missed appointment fee of up to \$150.00 (fee based on appointment length and/or number of missed appointments). Missed or broken appointments prevent others from receiving the dental care they deserve. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.