

Dental TLC Office Financial Policies

We the staff of Dental TLC thank you for choosing us as your dental care provider. We consider it a privilege to serve your needs and look forward to doing so. We are committed to providing you with the highest level of care and building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of our financial policy but also keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office.

We believe that this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients. Please understand that payment for services is an important part of the provider-patient relationship.

If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of benefits of insurance benefits, payment for services will be due in full at the time of service.

We make payment as convenient as possible by accepting cash, money order, Visa, Mastercard, Discover, American Express, Care Credit, Springstone, and checks for under \$100. A \$35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.

Assignment of Benefits: Our office is pleased to accept your insurance assignment. We offer this service as a courtesy to our patients. I certify that I _____, (or my dependent) have (has) dental insurance coverage and assign directly to Dental TLC all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or her staff to release all necessary personal information to my insurance company in order to secure payment of benefits. However, it must be clearly understood that the "contract" is between you and your insurance company, the account thereby being your responsibility for ANY amount not paid by the insurance company. I also understand that should my insurance company send payment to me, I will forward the payment to Dental TLC within 48 hours. I agree that if I fail to send the payment to Dental TLC and they are forced to proceed with the collections process; I will be responsible for any cost incurred by Dental TLC to retrieve monies.

Insurance:

1. Although we are willing to complete insurance information forms and submit a claim on your behalf, we do NOT accept responsibility –under any circumstance–for the outcome of the transaction. Completing insurance forms is a courtesy we extend to our patients in an effort to maximize the likelihood of obtaining reimbursement. By having our office process insurance forms, you agree to accept liability for those forms. We do expect you to be interactive and responsible for communicating with your insurance carrier on any open claim as requested by our office. Alternatively, you may fill out your own insurance forms and bill the insurance directly.
2. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any changes when they occur. Even a Preauthorization of services does not guarantee payment from your insurance carrier. It is your responsibility to know if our office is participating or non-participating with your insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, deductibles, and any out of pocket costs, as outlined by your insurance carrier. **You're estimated out of pocket portion will be due at the time of service.**

Please be aware that **out-of-network** insurance carriers often prohibit assignment of benefits and may try to limit their financial responsibility with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we will not negotiate reduced fees with your carrier.

3. Insurance payments are ordinarily received within 30 to 60 days from the time of billing. If your insurance company has not made payment to our office within 90 days you will be required to pay the balance due and then seek reimbursement from your insurance company.
4. As a courtesy, we will gladly contact your insurance carrier in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits once submitted and processed by your insurance company. Keep in mind that many insurance companies base their quoted percentage of coverage on their own fee schedule, and NOT our office's actual fees, which may result in a balance on your account.
5. ALL dental services rendered, whether or not covered by your insurance, are ultimately the financial responsibility of the account holder. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office does not allow partial payments unless you have contacted our office to make payment arrangements. It is your responsibility to follow up with your insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance company after the balance has been paid, a prompt refund will be issued.

Past Due Accounts: If payment is not received by the due date printed on the statement, then your account is considered "past due". There is a 5% per month billing charge on all past due accounts. If after 4 statements that account remains past due, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or attorney for collection, the account holder will be responsible for ALL attorneys and/or collection fees that Dental TLC incurs while attempting to collect on an unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Medical Records Fees: Patients are entitled under federal law to have access to their protected health information and we will follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records fees and our fees are a reasonable cost-based fee for copies including copying, supplies, labor and postage. There is a \$50 fee for a copy of cone beam CT scans due at the time of receipt and/or mailing. There is an additional \$4.95 mail fee for any records requested to be mailed.

Multiple requests for copies or transfer may be subject to additional clerical costs incurred in making records available.

Dental TLC has the right to update and make changes to the above stated office policies at any time without prior notification. Feel free to ask for an updated copy of office policies at each visit.

I acknowledge that I am responsible for all dental services rendered to me and my dependents (if applicable).

If you understand and agree to all the above office policies, please sign below and we will accept your insurance assignment.

Patient Name (print): _____ Date: _____

Responsible Party Signature: _____ Relationship to Patient _____

*This will serve as the responsible party's signature on file for the purpose of administering insurance benefits.