Financial Policy for Patient Care Services

To help provide the most efficient and reasonable health care services, it is necessary for us to have a *Financial Policy* stating requirements for payment of services provided to our patients. Patients are ultimately responsible for the payment of all services provided by our office.

DENTAL INSURANCE:

- As a courtesy, our office will file a claim with your primary insurance carrier on the date of service. We can assist you with secondary coverage.
- If you have dental insurance, your estimated portion of the charges (deductible or co-pay) is expected at the time of service.
- We ask that you notify the office if your insurance has changed.
- Since we are not a party to the agreement between you and your insurance company, we may ask that you assist us in contacting them in the event that services are not paid within 30 days.
- Insurance claims unpaid after 30 days are the responsibility of the patient.
- If we receive payment from the insurance company and you have already made payment for that date of service, we will prepare a refund for any overpayment and send it to you.

SELF PAY:

- If you do not have dental insurance and you are a "self pay" patient, we ask that you pay the entire balance at the time of treatment, unless Payment Plan arrangements are made with our *Finance Manager*.
- We accept cash, check, and major credit cards, such as *Visa, MasterCard, Discover,* and *American Express*.
- We also have a flexible payment plan called *CareCredit,* which allows you to start treatment today and spread payments over time. Both plans consist of an Interest Free Option and a low interest Extended Payment Plan Option, when you need more time to pay. Applying for approval only takes a few minutes and there is no fee to apply. Our financial coordinator can assist you in setting up a payment plan with *CareCredit* prior to your appointment.
- We participate in a program known as *Dental Banc* that can draft monthly payments from your checking account or enter charges on your credit card to save you the hassle of remembering to send a payment.

DISCOUNTS:

- If the account balance is zero prior to entering this date's services:
  - A 10% discount will be given when paying the full balance with cash or check.
  - A 5 % discount will be given when paying the full balance with credit card.
- *CareCredit* payment plans do not qualify for discounts.
- ***NEW - We offer membership in a discount plan through Danville Dental that includes $50 check-ups and 10% - 20% off all other dental work. Ask a receptionist for details.***

RETURNED CHECKS:

- There is a $25.00 service charge on all returned checks.

MISSED OR CANCELLED APPOINTMENTS & LATE ARRIVALS:

- Missed appointments, cancellations and late arrivals are a tremendous loss for a practice. Please help our office reduce those losses by canceling with at least 24 hours notice if you cannot keep your appointment.
- Failure to give notice 24 hours prior to your appointment may result in a $25 fee to be paid by the patient.
- Late arrivals of more than 10 minutes may result in rescheduling the appointment to another day.

DELINQUENT ACCOUNTS:

- Financial arrangements and regular payments must be made for balances carried on account by our office. Allowing an account to become seriously past due will result in being turned over to a credit bureau, collection agency and/or the court system. The responsible party will also be required to pay all fees associated with this type of action.

PATIENT INFORMATION:

- Patients are asked to provide Danville Dental Associates with current information (including name, address, phone, medical/health and employer changes, etc.) for themselves, their family members and their insurance company and to keep all changes up to date.
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I acknowledge that payment is due at the time of treatment, unless prior arrangements have been made with the Finance Manager before the appointment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. If I am insured, I understand that I am financially responsible for all charges whether or not they are covered by insurance.

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Signature of Patient or Responsible Party | Printed Name of Patient or Responsible Party | Date