

Financial Policy Christiana Dental Spa & Christiana Family Dental Care

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Prior to treatment, you must complete our patient information and medical history forms, read and approve our privacy policy and submit your insurance card for photocopying. We will also provide you with a copy of the "HIPAA Notice of Privacy Practices." Please ask if you have any questions about our fees, financial policy or your responsibilities.

Your appointment time is reserved exclusively for you. If you cannot keep your appointment, you must provide our office with a 48-hour notice to avoid a broken appointment fee of \$50.00. Also, please notify us 48 hours in advance of any insurance changes or it will be "Fee for Service" for that day. This allows us to verify your new insurance before your appointment. We will refund your money after your insurance company pays the claim.

We will do everything we can to inform you in advance of the anticipated costs of your treatment, including an **estimate** of the benefit your insurance company is likely to pay. Such information does not preclude the possibility that additional costs may be incurred if unanticipated treatment becomes necessary, nor will it absolve you of your obligation to pay for such treatment. Keep in mind that your treatment needs are not connected to or determined by your insurance benefits.

Insurance is a contract between you and your insurance company. Not all services are a covered benefit in all contracts. We file insurance claims as a courtesy to our patients. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-insurance, covered services, "usual and customary" allowances or other issues other than to provide factual information as necessary. **You, the patient, are ultimately and completely responsible for payment of your account.**

Payment for dental treatment is always due at the time of service. Insured patients are required to pay the **estimated** cost of their care at the time of service. If you do not have insurance, or if your insurance will not reimburse us directly (for example: Blue Cross Blue Shield), payment in full is expected at the time of service, unless otherwise arranged in advance.

There are payment options available for those who are unable to pay in full at the time of service. These options must be agreed upon prior to treatment being rendered. Please ask a member of our staff to further elaborate.

After 30-days of invoice date, all accounts are subject to interest. Interest at the rate of one and one-half percent per month will be added to your account until the balance has been paid in full. A non-sufficient funds (NSF) fee of \$50.00 will be added for each dishonored check. It is your responsibility to pay for any costs of collection including, but not limited to court costs, collection agency fees and/or attorney's fees, incurred by this office, our agent or our assignee.

If there is ever a dispute with respect to the amount owed on your account, you must notify this office, in writing, within 30-days of invoice date. For our mutual records, we suggest you send this correspondence via **certified mail**.

If for any reason your account is referred to a collection agency you will be responsible for any and all fees associated to collecting your debt. You and your family will be dismissed from our practice - both Christiana Dental Spa and Christiana Family Dental Care.

I have read the above policy and understand my responsibility for my account. **I, the patient, am ultimately and completely responsible for payment of my account and agree to the above terms.**

Also, I have received and read the "**HIPAA Notice of Privacy Practices**" and understand my rights as described in the document.

Signature of Patient or Responsible Party

Date

Complete Printed Name – First / Middle / Last / Jr, Sr, III, IV

Social Security Number

Assignment of Benefits

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to **Christiana Dental Spa and Christiana Family Dental Care** of the benefits otherwise payable to me.

Signature of Patient or Responsible Party

Date