Christiana Dental Spa's Financial Policy

Dentistry is a great investment and our patients deserve the Best Quality Dental Care. Your clear understanding of our financial policy is important to our professional relationship. Prior to treatment, you must complete out 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 of 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 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.**

Effective immediately, services for all restorative or major work (including but not limited to fillings, crowns, implants, and dentures) will require a 50% co-payment to hold your appointment. The balance due on the co-payment must be paid before final restorations are completed and/or delivered. Appointments missed without prior notice to our office will result in the responsible party's credit card being kept on file in order to make future appointments. Thereafter, there will be a $50 charge for each appointment which is missed without notice.

Patients without insurance, or those with insurance that will not reimburse us directly, must make payment in full at the time appointment is made. 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-half percent per month will be added to your account until 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 or our agent.

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.

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

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Signature of Patient or Responsible Party Date

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Completed Printed Name-First/Middle/Last/Jr, Sr, III, IV Social Security Number

Last modified 01/20/17