

R. L. Daschbach & Associates
Office Financial Policy

Please read the following document and discuss with either your hygienist or doctor. Thank you.

Thank you for choosing us as your dental care provider. We are committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

Regarding Payment

***We accept the following forms of payment: Cash, Check, Debit cards, Visa and Mastercard**

***Payment for services is due at the time services are rendered unless prior arrangements have been made.**

***Checks that are returned to our office are subject to a \$35 returned check fee.**

*** We also offer financing through CareCredit for those who qualify. With CareCredit, you can finance 100% of your dental treatment. There are no upfront costs, no annual fees and no pre-payment penalties. If this method is of interest to you, please visit their website at CareCredit.com and apply PRIOR to your dental appointment.**

OUR GOAL

Our goal is to help remove financial barriers so our patients can receive the dental treatment they need and desire. **After** your initial exam with one of our doctors, we will be happy to provide you with an **estimate of costs**. It is important to understand that treatment plans are subject to change depending upon the status of the patient's current dental condition. Many patients have some type of dental insurance. In the majority of cases, we are able and pleased to assist you in maximizing your benefits. At your first visit we will ask you for your current insurance information. **You** must provide all necessary information at that visit in order to utilize your insurance. **You** are responsible for confirming this information/advising us of any changes at subsequent visits so we can remain up to date and fully informed to serve you.

DENTAL INSURANCE

Your insurance policy is a contract between you, your employer and your insurance company, not your dentist. There are numerous different insurance companies, all with different deductibles, maximums and benefit coverage's. Any of these benefits can change **without notice**. We are **not** responsible for knowing these changes. It is important for you to familiarize yourself with your particular plan, current status and any changes. Most insurances do **not** cover 100% of the cost of your treatment. It is because of this and the extreme delay in receiving payment from insurance companies, that you are asked to pay your portion of the charges at the time services are rendered. All **estimates** are based on information provided to us by your insurance and **are not a guarantee of payment**. Only after a claim is submitted and reviewed by your insurance company can final payment be determined. For those patients with 2 insurances, we accept payment only from the primary insurance. **You are responsible for the balance after the primary insurance has paid**. The secondary insurance submission is your responsibility and payment will go directly to you. We will provide you with the necessary forms for submission.

In Network Insurance:

With **In Network** insurance, our office has a contract with the insurance company to accept their allowable fees. Even so, **you may have a balance due** on some procedures depending on your policy.

Out of Network Insurance:

When you have **Out of Network** insurance, you can still be treated here and the insurance company may make partial payment directly to our office. **You are responsible for the remaining balance.**

HMO/DMO Insurance:

You must go to an office that is on a list of preferred providers to receive insurance coverage. If you choose to be a patient in our office, you will be expected to **pay 100% at time of service.**

Will you be using any form of insurance to help pay your dental bills? _____ Yes _____ No

If Yes: Is it In Network: YES _____ NO _____ initials _____
 Is it Out of Network: YES _____ NO _____ initials _____
 Is it HMO/DMO: YES _____ NO _____ initials _____
 Other: YES _____ NO _____ initials _____

These insurance companies that are IN-NETWORK at our office. We will submit the claims for you. You are responsible for your **estimated** portion at the time of service. We will bill you for any balance after the insurance payment is received. You may have a balance due beyond your estimated payment.

Please indicate which insurance you will be using:

| | | |
|------------------------------|--------------|----------------|
| Assurant | Yes___ No___ | initials _____ |
| Blue Cross/Blue Shield GRID+ | Yes___ No___ | initials _____ |
| Anthem GRID+ | Yes___ No___ | initials _____ |
| Cigna PPO | Yes___ No___ | initials _____ |
| Delta Dental Premier | Yes___ No___ | initials _____ |
| United HealthCare PPO | Yes___ No___ | initials _____ |
| Lincoln Financial Group | Yes___ No___ | initials _____ |

All other insurance companies are OUT-OF-NETWORK.

If your dental insurance provider is **OUT-OF-NETWORK**, we will gladly submit your claim. However, out of network fees **will** apply. An estimated fee will be calculated and **due the day of service.** *Please keep in mind: Insurance companies that are out of network may say they will pay 80% of allowable fee. This means they will pay 80% of THEIR allowable fee, not 80% of our fee.*

Other Insurance Companies are HMO/DMO

Patients who have any of the following insurances that are considered HMO/DMO companies will be expected to **pay in full the day of service**. You must choose a dental provider from a list of preferred providers in order to receive any insurance reimbursement from an HMO/DMO.

| | | |
|------------------------|------------------|-------------------------------|
| Blue Cross Blue Shield | CHIP | Delta Care USA |
| DentaTrust | All HMO plans | Frank M. Vaccaro & Associates |
| Keystone | Medicare | Medicaid |
| Teamsters/Welfare | United Concordia | any other HMO or DMO |

We want to emphasize that as dental care providers, our relationship is with you as our patient, and not with your insurance company or employer. Although we will file dental claims with your insurance company, all unpaid charges are ultimately the patient’s responsibility.

- In consideration of the services provided to me by the office, I agree to pay in full my estimated portion at the time of service. I also agree that I shall be responsible if a balance remains once insurance has paid and will pay it in a timely manner.
- I grant permission to you and the staff to telephone me at any time to discuss matters related in this form (this includes my immediate family who are under my insurance)
- I have read and fully understand the conditions of treatment.

Cancellation/No Show Policy

We understand there may be times when you are unable to keep a scheduled appointment. We require a 24 hour notice to avoid a \$35 cancellation fee. We will be unable to schedule another appointment until that fee is paid in full.

I understand the office financial and cancellation policy.

Patient Name

If minor, printed name of responsible party

Signature of responsible party

Date