CHESTER FAMILY DENTAL CARE, LLC

Office, Dental Insurance Information and Financial Policies

Dear Patient:

Thank you for choosing our office for your dental needs. We would like to acquaint you with our policies regarding dental insurance, schedule changes etc. We always strive to maintain quality dentistry with compassion in a comfortable and friendly atmosphere. We would like to welcome you and your family to our dental family.

Since we know it is not always possible to pay your dental bill in full, we would like to explain our financial options. Please choose the option the works best for you.

♦**Dental Insurance**-**If you have dental insurance, as a service to you, we will complete your insurance form with all the necessary information and submit it to the insurance company. We ask that you pay the estimated co-payment at the time services are rendered. If you fail to bring the required insurance information to your appointment(s) we will ask that you pay the bill in full and be reimbursed from your insurance company with paperwork provided by our office. Our office does not guarantee that your insurance company will pay for the treatment you receive from our practice. If your claim is denied or the treatment is down-coded and or alternative benefits given, you will be responsible for paying the full balance amount left on the account at that time. _____ (please initial)**

Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to settle the claim.

♦**If your insurance company has not made a payment within 30 days of billing, the balance will become your responsibility. (Insurance coverage is a contractual agreement between the insurance company and you or your employer. We have no control over this relationship).**

♦**Payment is due at the time treatment is rendered. We accept Cash, Personal checks, Master Card and Visa charge or debit cards.**

♦**Monthly payments- If you need to make long-term payments we can offer financing with Care Credit. You must qualify to use this option. Or we can offer a two-month payment plan with a credit card on file.**

All patients with an outstanding balance will receive a statement each month. There is a finance charge of 1.5 % (18% APR) on all accounts 60 days overdue. If you have a returned check you will be charged a return check fee of $50.00 per check.

We reserve the right to charge for appointments broken with out proper 48 hours notice. The length of the appointment scheduled will determine a charge for the broken appointment. There is a minimum charge of $35.00 for a broken appointment cancelled with less than 24 hours notice.

SIGNIFICANT EXPOSURE- Section SC 44-29-230. (CONTROL MEASURES– HIV) for the State of S.C. provides that in the event of significant exposure (e.g. needle stick), consent for testing for Human Immunodeficiency Virus (HIV), Hepatitis B Virus and Hepatitis virus is considered to have been given by the patient and /or healthcare worker thereby granting the Hospital the right to perform such tests. Test results are confidential and can only be released in accordance with applicable laws and the policy of a local hospital.

Minor Patients- The adult accompanying the minor is responsible for the payment on the account. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, a MC/VISA, cash or check, payment is paid on the account at the time of service.

I authorize and release information and payment of my dental insurance to the dentist.

I have read and understand fully the financial options. I agree to accept responsibility for payment of my bill and my family member's bill _____ (names of the family member's) including co-pays, deductibles or non-covered services requested by me. In lieu of a refund, I authorize any credits on any family member's account to be transferred to any family member's account balance and I understand I will be billed for any outstanding balance after the credit is applied to the outstanding balance/s unless otherwise directed. I understand that in the event my account becomes delinquent I will be responsible for any collections, attorney fees at 33 1/3%, court costs, interest (and any other charges incurred to collect this account) on the principal balance of 18% (eighteen) per annum from the date of service. In the event the account is turned over to collections you will need to discuss all payment arrangements with our attorney.

_____ _____

Signature of patient, parent or guardian **Date** **rev. 12/15**