HOCKESSIN DENTAL
FAMILY & COSMETIC DENTISTRY
6300 Limestone Road Hockessin, DE 19707
302-239-7277 Fax 302-235-8598

# Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychosocial care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following arrangements regarding their dental treatment.

- **Patients without insurance coverage need to know...**
  The fee for the treatment rendered must be paid in full on the day of service.
- **Patients with dental insurance coverage need to know...**
  The ***estimated*** patient co-pay and deductible for the treatment rendered must be paid in full on the day of service. Please understand that you are ultimately responsible for all balances generated by your treatment.
- **We accept cash, check, debit cards, CareCredit, LendingClub and the following major credit cards: VISA, MasterCard, and Discover**

**Payments:**

Payment is expected at the time services are rendered unless arrangements have been made prior to the appointment. For patients wishing to make extended payments, we offer third-party financing through CareCredit and LendingClub. CareCredit and LendingClub allow low monthly payments for qualifying applicants. Unless we approve other arrangements the balance on your account is due and payable within 30 days after the balance is incurred.

**Hockessin Dental does not send monthly statements or bills. A billing charge and finance charge will be applied if a statement needs to be sent to your home.**

*A billing charge of $5.00 will be processed to your account if for any reason after 30 days we have to mail a statement to you. Any charges that are not paid within 90 days will incur a monthly financing fee of 1.5%.

We keep your credit card information securely on file; we will charge your credit card the balance of all charges not paid by the responsible party or your insurance company after a 90 day period. For our patients with insurance, after the submission of all forms, x-rays, and appropriate information to your insurance company on your behalf your card will be charged within 30 days of receiving an explanation of benefits. We will contact you via email or telephone call to inform you of any balance to your account. You are able to make different arrangements at that time with our financial coordinator if you do not wish to use the card left on file with us.

**If you do not wish to leave your credit card number on file with us, you have the option to pay in full at the time of service and have your insurance company reimburse you directly. As a courtesy, we will submit all necessary forms to your insurance company on your behalf.**

**Returned Checks:** There is a fee (currently $55) for any checks returned by the bank.

**Insurance:**
Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Please note that services rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment and all balances generated by your treatment. If your insurance company has not paid your claim within ninety (90) days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage.

**We ask you to provide the following information to facilitate your account processing:**

Cardholder Name: _____

Card Type (circle one): VISA MasterCard Discover

Account Number: _____

Expiration Date: _____

Security Code (3 digits on the back of card):_____

Cardholder Signature_____

Email Address: _____

**For patients WITH insurance:**

I acknowledge that it is my responsibility to understand the terms of my dental coverage and to contact my insurance to get specific details on what my yearly allotment covers or does not cover. In addition I understand that I am responsible for the cost of treatment not covered by my insurance.
**Insurance Release:**
You authorize Hockessin Dental, P.A. to release any necessary information requested by your insurance carrier. I authorize payment directly to Hockessin Dental, P.A. and assign any benefits to Hockessin Dental, P.A.

Signature: _____ Date: _____

**For ALL patients:**

This is an agreement between Hockessin Dental, P.A. and the Patient named on this form. By executing this agreement, you consent to treatment by Hockessin Dental, P.A. and agree to pay for all services that are received. Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name: _____

Signature: _____ Date: _____