Luray Family Dental
Financial Policy

Welcome! Thank you for choosing us as your dental health care providers. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask question and to be involved in treatment decision. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Patients are expected to pay for services at time they are rendered. Our patients who dental insurance are expected to pay the amount of treatment of their estimated co-pay and deductible at the time of service. Your estimate co- pay for treatment, which is the amount not covered by your insurance, is due at the time treatment depending upon the reconciliation of the insurance payment.
Payments may be made using cash, visa, MasterCard, flex spending cards, American express, and/ or discover. **PERSONAL CHECKS ARE NOT ACCEPTED.** We also offer CARECREDIT, a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance. There will be a $25 late fee charge after 30 days. Accounts over 90 days are subject to our collection agency.

There will be a fee for any additional procedure NOT included in original treatment plan.

For minor patients, the responsible party for the account **MUST BE PRESENT.** If the minor has insurance through a person not present, we will inform you of the information required by our office to bill the insurance company, **WE WILL NOT BILL A THIRD PARTY THAT IS NOT PRESENT TO SIGN THIS FINANCIAL POLICY.**

APPOINTMENTS:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least a 24 hour notice for any cancelled appointment. There is a $50 fee per hour for missed appointment, waived the first time. After 3 missed appointments or cancelled appointment we will not reserve an appointment for you. We will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has opening for a dental appointment within the next few hours.

INSURANCE INFORMATION:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy with you on your first visit of every calendar year (your insurance may not run January-December). If your insurance plan changes please let us know as soon as possible.

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OUR DENTISTS WILL DIAGNOSE TREATMENT BASED ON YOUR DENTAL HEALTH, NOT YOUR INSURANCE COVERAGE.

YOU MUST REALIZE THAT:

Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by buys an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment. For example, a dentist may recommend a crown for tooth that has extensive decay; however, the dental plan may only cover the cost of filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and BE reimbursed when your insurance company pays. After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided to assist in your inquiries. **The insured has a better ability to deal with the insurance company and the employer responsible for the policy.**

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the financial policy also shall cover your dependent children who are patients of the practice.

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Patient(s) name PLEASE PRINT

_____

Responsible party signature (&PRINT if other patient) **Date**

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Date of Birth of Responsible party **SSN of Responsible party**