

DR DANIEL MCEOWEN & DR KEVIN CHAI FINANCIAL / INSURANCE / APPOINTMENT AGREEMENT

1. Authorization

I authorize Daniel C. McEowen, DDS, LLC. and Middletown Valley Dentistry to release any information, including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care, to third party payers. I authorize and request that my dental insurance company pay directly to Daniel C. McEowen, DDS, LLC., dental insurance benefits otherwise payable to me.

2. Insurance

Your insurance coverage is a contract between you, your employer, and your insurance company. We are not a part of the contract. We will be happy to bill your primary insurance carrier for you; however, we will require your social security number to be kept on file. Any copay, co-insurance or non-participating insurance portions will be due in full at the time of service. Although we attempt to estimate your portion due at the time of service, **THIS IS ONLY AN ESTIMATE**. The exact amount can only be determined after receipt of the actual insurance payments. In the event that your dental insurance determines a service to be "not covered" you will be responsible for the total charge. In that event we will bill you, payment is due upon receipt of that statement. If your insurance company requires a referral and/or a preauthorization, you are required to obtain it. It is your responsibility to monitor your insurance benefits and annual maximum. We are happy to assist you with any resubmissions, but we cannot make calls to your insurance company on your behalf.

We will file with any secondary insurance carrier we currently accept.

Daniel C. McEowen, DDS, LLC. only submits dental insurance claims, with the exception of medical claims for sleep apnea. If you believe treatments or diagnosis should be billed to any other type of insurance, such as medical, we will provide you with copies of the dental insurance forms enabling you to submit to your medical insurance. Payment would be due at the time of service and any insurance reimbursement from these claims will be sent to you.

If our office participates with your dental insurance plan no additional discounts will be offered including 0% financing through Care Credit. Care Credit Standard Account Terms and Reduced APR financing options would still be available to you.

3. Payments

All charges not billed to dental insurance are due and payable at the time of service. For non-insured patients we offer a 5% cash discount for procedures that are paid in full by cash or check. We offer a 10% cash discount for procedures that are paid in full by cash or check for non-insured patients over the age of 65. Both discounts cannot be combined.

- I understand that I am financially responsible for all charges. I understand that any outstanding insurance balance that is due over 45 days will become my complete responsibility. If it is necessary to bill you and the payment is not received by the posted due date on the statement a late fee of \$20.00 will be assessed for each month the account is not current.
- Returned checks will be subject to a \$36.00 processing fee to cover bank charges. If your check is returned for non-sufficient funds we will accept only cash or credit card payments.
- If your account is not kept current, additional appointments cannot be made.

- If a collection agency become involved in the settlement of your account, you agree to pay a 25% collection fee in addition to your account balance. You also agree to pay any court costs, attorney fees allowed by law in the collection of your account,

4. Appointments

Appointments are reserved in advance for you and your family. Since your individual appointment time with the Doctor or Hygienist impacts the daily schedule of the office we require that you give 48 hours advance notification of any scheduling change. Broken appointments are any appointment that are cancelled less than 48 hours before the appointed time. I acknowledge there is a \$50.00 fee for each broken appointment,

Children of 2 Households- The parent or legal guardian requesting treatment for the child will be held accountable for all charges for services rendered. If the divorce decree requires the non-present parent to pay all, or part, of the treatment costs, it is the requesting parent's responsibility to collect from the other partner after settling the account with our office.

5. Your Responsibilities

It is your responsibility to: update the office with any and all insurance policy changes.

Please update all new addresses, phone numbers and employment information.

We want you to have safe treatment so we will ask you to update your health history and medications at least once yearly. Should you have any changes to your medical history or medications prior to a request for an update, please inform a member of our staff.

APPROVAL AND AUTHORITY TO PROCEED

Approved By

Date

Approved By

Date