ALLENTOWN DENTAL

Patient/Parent Name _____Date of Birth _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental provider. We are committed to providing you with the highest quality dental care, so that you may obtain optimum oral health.

The following statement is our Financial Policy, which we require that you read, agree to, and sign prior to any treatment.

Please note: Payment is due at the time of service provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, and CareCredit. Additional Fees will be applied for returned checks. All account balances over 90 days are subject to a $35 late fee.

Do you have dental insurance?

- **You need to bring** your insurance card and coverage booklet at your first visit, and at any time your insurance changes.
- **We will always do our best** to help you maximize your benefits.
- **Although we file claims for you as a courtesy,** your dental insurance policy is a contract between you, your employer, and your insurance company. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. We will do all we can do to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- **Not all services are covered benefits in all contracts.** Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. We are happy to help with this.
- **We ask that you** pay the deductible, co-payment, and co-insurance, which is the estimated amount not covered by your insurance company, at the time we provide service to you.
- **Insurance payments are ordinarily received within 30-60 days** from the time of filing the claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

ALLENTOWN DENTAL

- **We will cooperate fully** with the regulations and requests of your insurance company that may assist in your claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment. Delinquent balances over 90 days old will be referred to a collection agency. All referred accounts are marked "Inactive". In order to have your account "Reactivated" and continue receiving dental treatment in our office, delinquent balances must be paid in full.

Your dental appointments are scheduled carefully. Our goal is to provide treatment in a timely manner with as few visits as necessary. Time, trained personnel and dental equipment are reserved for each procedure. In order to provide the best service to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. If you know that you are unable to keep your appointment, we ask you show consideration by canceling your appointment at least 24 hours in advance. This allows us adequate time to schedule another patient who needs to be seen. A fee will be incurred for missed appointments and short notice cancelations. Multiple failed appointments may result in being dismissed from the dental practice.

Consent:
I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier.

_____ _____

Patient (or parent of minor) Date