DEAN COSMETIC DENTISTRY CENTER
Advanced Technology in a Relaxing Environment

FINANCIAL / OFFICE POLICIES

Thank you for choosing Dean Cosmetic Dentistry for your dental needs. We pride ourselves on our thorough communication with you, our patient, to make sure all questions are answered & you have any & all information you may need regarding your treatment.

In order to enhance communication and promote understanding regarding this office's financial policies, please read the following information & provide your signature below indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment. If you have any questions or concerns, please speak to the office manager.

INSURANCE POLICIES & PROCEDURES

Please understand that each patient is ultimately responsible for the cost of services rendered. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our financial relationship is with you, not your insurance company.

We will do our best to **estimate** insurance coverage & patient portion due. As a courtesy to our patients, we diligently verify your personal insurance plan coverage to best **estimate** your office fees. Unfortunately, we are not able to figure an exact amount of payment by a simple insurance verification. To make sure we are in agreement, we highly encourage you to be educated on your personal insurance plan. If we are not an in-network provider, fees may vary due to a difference of fees in each plan and/or insurance carrier. Understanding your policy will help us communicate clearly, as your service provider, to create a treatment plan that is most accommodating to you. If your insurance company does not pay the full amount anticipated, the patient is responsible for the difference. If your insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, personal check, major credit card, and Care Credit.

If you do not wish for us to contact your insurance company personally, you are ultimately responsible for any unpaid balances your policy does not cover. *see the Insurance Policy for more details

PATIENT PAYMENT

Payment is due at the time services are rendered. Balances over sixty (60) days will incur an interest charge of 1.5% per month & after 90 days, an additional $5.00 rebilling fee per statement will be charged. Returned checks will have an additional fee of $25.00 added to the amount of the returned check. Payment is expected within 10 days after the statement date. Please contact the office manager for more information on any of the above payment options.

FINANCIAL ARRANGEMENT

When there is treatment beyond preventive care needed there will be a financial arrangement form completed and further discussion of insurance or out of pocket expense will be discussed.

REFUNDS FOR UNFINISHED TREATMENT

Please understand that if a patient decides to discontinue treatment after it has been started, a full refund will not be given. Individual circumstances may be discussed with the office manager and/or the dentist.

CREDITS ON AN ACCOUNT

If an insurance company pays more than anticipated creating a credit for the patient, we are happy to either refund the credit or leave a credit on the account to be applied towards future treatment.

Patient/Parent/Guardian Initials _____

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MISSED APPOINTMENT FEE

Please remember that we have reserved this time especially for you. Therefore, we request at least a 48-hour notice in order to reschedule your appointment. A $63 fee will be charged to your account per failed appointment. This amount is not covered by insurance and is your responsibility.

INFORMED CONSENT

I am consenting for treatment for myself or I am the parent, guardian, or personal representative. There are no court orders now in effect that prohibits me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the patient named above, including but not limited to radiographs, administration of anesthetics, and all dental procedures which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days from the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

MEDICAL HISTORY

To the best of my knowledge, the Medical History form has been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

INSURANCE ASSIGNMENT CONSENT

I certify that myself or my dependent is covered by dental insurance and assign directly to Donnie Dean, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use mine and/or my child's health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I have received or read a copy of the Dean Cosmetic Dentistry Notice of Privacy Practices.

We appreciate your loyalty and understanding our financial/insurance policies and procedures. We hope to always exceed your expectations and hope that these procedures will create a more positive relationship with our office and you. Thank you again for choosing us and we look forward to making your smile even more beautiful.

I have read, and understand the Dean Cosmetic Dentistry Center's Financial/Office policies.

Signature of Patient or Responsible Party

_____ **Date:** _____

Signature of Dean Cosmetic Dentistry

_____ **Date:** _____