FINANCIAL POLICY & AGREEMENT

PATIENT RESPONSIBILITY:

Patients are responsible for all charges resulting from treatment provided by **Bogdan N. Bodroug, DDS, PS** (an estimate will be provided for you during your consultation). Keep in mind that this is an ***estimate only*** and the actual amount paid by your insurance company may be less than the original estimate. As a service to you, we will bill most insurance carriers directly. However, primary responsibility for the account is yours. Patient co-pay is due on the treatment date, unless other financial arrangements are made ***prior*** to that appointment.

*Minors: The undersigned will agree to be responsible for payment of balances for services rendered to minors 18 and younger.

APPOINTMENTS:

We know that life doesn't always go according to plan. We will contact you immediately if there needs to be a change to your appointment time. We ask the same consideration from our patients. **Please give us at least 24 hours of notice should you need to cancel or change an appointment for any reason.** Given the nature of dental appointment time, it is very often not possible to find a patient to fill the missed or cancelled appointment time on short notice. **Due to this fact, there will be a $50.00 charge for any appointment cancelled less than 24 hours.**

PAYMENT ARRANGEMENTS:

Payment is expected at time of service. Cash, Checks, Debit, Visa, MasterCard, and Discover, can make payment. If a payment plan is what you need, our office offers 3rd party financing through **CareCredit**. We can complete the application for you online or you can contact them at 800-365-8295 or www.carecredit.com. Zero interest financing may be available upon approved credit. There will be a $25.00 service charge on all returned items. **Balances over 90 days will accrue a FINANCE CHARGE of 1.5% that will be added to your account each month that the account is past due. This represents an ANNUAL PERCENTAGE RATE OF EIGHTEEN PERCENT (18%).** Delinquent accounts over 120 days will be referred to a collection company.

IF YOU ARE COVERED BY INSURANCE:

For our office to accept assignment of benefits from your dental plan, it is important that you read our policy and accept the requirements set forth:

In order to submit a dental claim on your behalf, it is necessary that you provide our office with accurate and complete information for the insured party. ***Patients with insurance are expected to pay their estimated co-pay in full at time of service***. As a courtesy, we will bill your insurance for you, both primary and secondary if applicable. However, it is important that you understand your benefits and any exclusions of your insurance coverage as defined by your plan. Our office can assist in helping you understand your insurance plan but it is ultimately your responsibility. Many insurance plans state that they cover 50%, 80%, or 100%. In actuality, many plans may cover less than that, depending upon their established **"usual and customary fee"** and what services they will actually cover. Insurance companies use the phrase **"usual and customary"** when setting fee limitations on services. Be aware that some companies will only pay a claim percentage based on their own **"usual and customary fees"**, not on our actual charges. In order to determine exactly what portion of your total bill will be covered by your insurance, we will be happy to request pre-authorization for you. This will usually require 3-4 weeks to be processed by your insurance company. If insurance payment has not been received within 30 days of billing, you are expected to contact your insurance carrier regarding the delay. If necessary, we will submit a claim for payment to your dental plan up to two times. However, if there is no resolution, it is the responsibility of the insured to contact their dental insurance carrier to seek payment. **If no insurance payment has been received within 45 days after billing, you will be expected to make full payment.** Please remember that an insurance contract is **(*between you and your insurance carrier)***. We are not a party to that contract. ***Therefore, you are ultimately responsible for payment of all charges incurred in this office, whether your insurance carrier pays for services rendered or not***. You are also responsible for any finance charges on any outstanding balances. Please understand that occasionally it can be difficult and frustrating to receive payment from an insurance company. Our office is committed to helping you understand this process and to assist you, within reason, in receiving the benefits to which you are owed. Incomplete or inaccurate information will often result in a denial of the claim. As a result, you will likely receive a statement from our office for the full amount of the balance on your account. Future services, both dental and clerical may be delayed or refused until the balance is cleared. If your personal payments plus the insurance payment exceed the total cost of service, the excess will be refunded to you.

PROFESSIONAL DISCOUNTS:

Quality Dental Care is pleased to offer a 5% CASH DISCOUNT to uninsured patients paying by Cash or Check**. Patients who carry insurance may also qualify for this 5% Cash discount, provided those patients pay for their treatment in full and agree to be reimbursed directly by their insurance carrier. Cash or insurance patients who pay for their complete treatment plan costs prior to starting treatment with Cash or Check will receive a 10% Discount off the total treatment plan estimate. Senior Citizens 65 and older will receive a professional courtesy discount of 10% off dental services. ****Special "Coupon" pricing does not qualify for any additional discounts and cannot be combined with any other special promotions or offers.**

I hereby authorize release of any information to my insurance carrier regarding my claim. I also authorize any insurance benefits to be paid directly to Dr. Bogdan N. Bodroug. My signature below indicates this authorization. I have read the above, understand and agree to it.

SIGNATURE OF PATIENT/RESPONSIBLE PARTY: _____DATE: _____