Financial Policy for the Office of Dr. Kinberly Antrim

This form explains to all of our patients the billing process only of the office. For answers to any other questions you have, please ask any of our trained staff members -- we're here to help!

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patients pay for their treatment in full on the day of each visit to our office unless prior arrangements have been made.

We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visit's total bill. Please bring cash, check or credit card at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate.

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, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement.

Delinquent balances over 90 days old are subject to collection action. All referred accounts are marked "Inactive". In order to have your account "Reactivated", and continue to receive dental treatment in our office, the delinquent balance must be brought up to date. Only after this total account balance has been paid in full can appointments be made and your account and patient status be reactivated.

A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear must be paid in cash, or by VISA, MasterCard, or Discover.

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 24 hours advance notice for rescheduling or cancelling your appointment. Your account will be charged a broken appointment fee of $100.00 for repeatedly missed appointments without proper notification.

Office Policy for Patients with Dental Benefits

Please be aware that:

• **We will always do our best** to help you to 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. We are not a party to that contract (we may not be a participating provider).

• **Your treatment plan is individually tailored,** and is not based on your dental insurance benefits or lack of benefits.

• **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. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

• **Our staff is trained to help you** with questions you may have relating to how your claim was filed, or regarding any additional information your carrier may need to process your claim. Please, ask if you have any questions.

• **As a courtesy to all of our insured patients,** we will file your dental insurance claim forms. In special circumstances, a particular insurance company's benefit check can be sent to our office directly. In such cases, you are responsible at the time of treatment for payment to us of any applicable deductible and for your coinsurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited accordingly. **Monthly accruing interest at the rate of 1.5% in addition to a billing fee of $5.00 per monthly statement can be avoided if your personal financial responsibility is clear within 30 days of your treatment, thereby eliminating the need for statements to be generated and mailed to you.**

• **Your claim will be filed immediately, and benefits are expected are to be paid within 30 days.** The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 45 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason. Any amounts expected to be paid by your insurance company, but not cleared by them within 45 days become your responsibility and, if not paid in a timely fashion, will begin to accumulate interest at the rate of 1.5% per month with the billing fee of $5.00 per monthly statement. *Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail*.

I understand and accept *the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction.* ***I agree*** *to pay for all treatment in a timely fashion as described so as to avoid any additional fees. [For those patients with dental insurance who would prefer that their insurance company send payment to this office.] I hereby authorize my insurance benefits to be paid directly to Dr. Antrim. I realize that I am responsible to pay for any deductible amount(s), my coinsurance portion and for any non-covered services. 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(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.*

X_____ X_____

PATIENT (or parent of minor) DATE STAFF INITIALS