

FINANCIAL/APPOINTMENT POLICY

Thank you for choosing DentCare Now as your dental provider. We are privileged to have you as a patient and are committed to providing you with the best care. We have adopted the following financial policy which we require that you **read, agree to, and sign prior to any treatment.**

APPOINTMENTS- We reserve a room and prepare materials specific to your appointment needs. Prior to your appointment, our office will send email and text reminders and confirmations. If no response is received, you will receive a phone call. It is important that you confirm your appointment promptly to avoid misunderstandings or missed communications.

Deposits of 50% of the treatment is due at the time of scheduling, deposit is non refundable if canceled within less than 48 hours.

Failure to provide us with adequate notice of cancellation can waste our valuable resources. Cancellation(s)/Rescheduling should be completed via phone, email, or text. If an existing patient fails to keep their appointment without notifying the practice within 24 hours or more, a **missed appointment fee of \$15** will be subject to be applied to your account. For those patients with scheduled treatment, **48 hour** notice is required.

Multiple missed appointments without sufficient notice may cause dismissal from the practice in order for us to provide care to other patients. Exceptions to this policy are new patients, existing patients with emergencies, or unforeseen events beyond the patient's control.

For **new patient same-day emergency appointments** where you also **have insurance**, we allow and require payment in full upon the date of service due to the insurance verification process.

INSURANCE- The Insurance Policy is an agreement between you and your insurance carrier. It is your responsibility to know if the provider is participating or nonparticipating with your insurance plan. As a courtesy, we will bill your insurance and help you to receive the maximum allowable benefit for rendered services under your policy. You are responsible for providing the practice with the most recent, updated insurance information to ensure the most efficient billing process. **Photo identification is required with your insurance card** to prevent insurance fraud.

We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract. Our office is a participating provider for a few select insurance companies and, as a courtesy; we will bill your

insurance. You will, however, be responsible for any co-payment and the portion that your insurance does not cover.

Insurance is strictly an estimate not a guarantee of payment. We ask that you sign this form and/or any other necessary documents that may be required by those specific insurance plans. This form instructs those special insurance companies to make payments directly to our office.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will cooperate fully with the regulations and requests of those specific insurance companies that we are providers for. Our office will not, however, enter into a dispute with your insurance company over any claim.

PAYMENT- ALL Payments are due in full at the time of service. If you do not have insurance or proof of insurance, payment for services will be due at the time of service unless a payment arrangement has been approved by our staff in advance, prior to your appointment. If you have insurance, your patient portion (copay) is due at time of service. In addition, regardless of the status of the claim, you are responsible for the balance due on your account including any and all deductibles, co-pays, and estimates which are due at the time of service.

We accept Cash, Checks, Visa, MasterCard, and CareCredit, Alphaeon, Sunbit, Cherry, Lending Club. A \$35 service fee will be charged for all **returned checks**. **For any and all major services, if not paid in full, a credit card on file is required.**

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For Orthodontic Patients: Treatment times differ from patient to patient. These payment options do not correspond to the estimated treatment time but are merely provided for your convenience. All charges you incur are your responsibility regardless of your insurance coverage.

If for any reason you choose to not continue with treatment and a refund is warranted, the refund will be based on a prorated calculation of estimated length of treatment compared to months completed. The maximum refund will be 50% of the initial fee. Orthodontic retention is a separate fee not included in your cost of treatment. This is the patient's responsibility to remit payment for this service at the time of retainer impression. Our office will be held free of liability for incomplete treatment if you fail to keep your scheduled appointments. If for any reason you fail to pay while in treatment your case will remain in maintenance until your balance is paid, at which time treatment will resume. We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

CARD ON FILE- You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notify us of any additional amount owed by you, At the time, we will notify you that your outstanding

balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have any questions about your balance. We will send you the receipt for the charge.

This “Card On File” program simplifies payment for you and eases the administrative burden on your provider’s office. It reduces paperwork and ultimately helps lower the cost of healthcare. Your statements will be available via your portal and our customer support line is available to answer any questions about the balance due. If you have any questions about the “Card On File” payment method, please let us know.

UNPAID BALANCE- Any unpaid balance will be charged interest of 3% per additional 30 days on all accounts exceeding 60 days from the date of service unless there is a financial agreement signed prior to the treatment. Unpaid balances over 365 days will be turned in to the **collection agency**. You will receive a statement from our office either by mail, or emailed through your patient portal.

Please Note: In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

My signature confirms that I have read, understand, and agree with the above financial policy:

I @PAT_FIRSTNAME @PAT_LASTNAME agree to the financial agreement