Financial and Office Policy

Thank you for selecting us for your dental care team. We take great pride in our office and our abilities to render the finest dental care.

We strive to provide the best possible care and services to our patients. The appointments are scheduled carefully, and this time is reserved solely for you. Any change in scheduling affects other patients as well as staff members and the cost of dental treatment. As a courtesy, we will do our best to confirm your appointments, however, it may not always be possible to reach you. If you need to reschedule an appointment, please allow 48 business hours' notice. We understand that emergencies occur and allow shorter notice for 2 missed appointments per calendar year. After that, any missed appointments without the 48-hour notice will be charged $50.00. Patients may be asked to reschedule the appointment if they arrive late not allowing enough clinical time to render optimal treatment. Any visits after hours are charged at a higher fee.

Payment is due when the services are rendered. We accept cash, check, Visa, Mastercard, Discover, and American Express. As a courtesy, we submit insurance claims for you to receive benefits. Please keep in mind that your dental insurance policy is a contract between you, your employer, and your insurance carrier. We cannot act as a mediator between them. Our staff is trained to help you with questions regarding the filing of your claim. We will provide any additional information required by your insurance to the extent of our knowledge on your past dental history. You are responsible at the time of treatment for payment to us for any deductibles and co-insurance estimates. You are responsible for any amounts not covered by the insurance company. Please contact them directly with any questions regarding unpaid benefits.

If your insurance company pays benefits directly to the subscriber (you), payment in full will be due at the time of service unless prior financial arrangements have been made. If another form of payment method is necessary, we do ask that these arrangements be made prior to services being rendered. Any personal balance over $200.00 or outstanding insurance balance over $400.00 needs to be cleared before any more treatment is rendered and added to your account. A scheduled appointment may need to be postponed keeping account balances within these amounts.

Any balance not cleared within 30 days will incur a monthly billing fee of 5%. We ask that any outstanding balances are taken care of promptly to avoid these additional charges. There is a returned check fee of $50.00. Any returned checks must be cleared with another form of payment besides check.

FINANCIAL AUTHORIZATION AND ASSIGNMENT OF BENEFITS AGREEMENT

I understand that I will be informed of all proposed treatment and the associated fees prior to initiating the dental care. I agree to be responsible for all charges for dental services provided to me or my dependents. To the extent of the law, I consent to the use and disclosure of my personal health information to carry out payment activities in connection with dental insurance claims.

Your insurance policy is a contract between you, your employer, and/or your insurance company. Grape Lakes Family Dental is an Out of Network provider with all dental insurances, and it is your responsibility to know your insurance contract and coverage for such status. We will submit the claim on your behalf and accept your insurance reimbursement, but you are responsible for any unpaid remaining balance for treatment rendered. Submitting an insurance claim is not a guarantee of payment from the company. Our practice will accept an assignment of benefits from your insurance company with the following conditions:

Please initial each line.

_____ Although we complete insurance forms and submit claims on your behalf, **Grape Lakes Family Dental does not accept responsibility for the outcome of the transaction.** This is a courtesy we extend to save your time and to facilitate payment to our practice from your insurance company. By our practice processing the insurance forms, it does not eliminate your financial obligation for your treatment.

_____ We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company.

_____ We require payment of the estimated co-insurance, the amount not covered by the insurance policy, at the time services are rendered. **The co-insurance is only an estimate and may be insufficient after the claim is reviewed by your insurance company.**

_____ Insurance payments typically are received within 30-60 days from the time of submitting. **If the insurance company has not made payment to our practice within 60 days, you will be required to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company.** Our office will not enter a dispute with your insurance company over a claim. We will provide necessary documentation to your insurance company upon request to address questions that arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately, your responsibility to resolve any dispute over payments, made or not made by your insurance company to our practice. You have the option of being reimbursed directly from your insurance company. If you choose to do so, the entire payment is due at time of service.

_____ If payment is not received within 30 days after date of service, a 5% late fee will be charged to your account balance. An additional 5% will be applied every 30 days thereafter.

_____ Grape Lakes Family Dental office does not guarantee that your insurance company will pay for treatment rendered here. We perform routine insurance billing processing. **If your claim is denied, you will be responsible for paying the full amount at that time.**

______ Patients with no dental insurance are responsible to pay in full at time services are rendered unless prior arrangements have been made with the office.

______ If payments are not received within 90 days, the balance will be transferred over to a third—party collection, unless prior arrangements have been made.

I understand and accept the financial and dental insurance policies listed above. I agree to pay for all treatment promptly to avoid any additional fees. I understand that I am financially responsible for all charges of dental treatment, whether paid by said insurance. I also hereby authorize the release of pertinent medical/dental information to the insurance provider(s).

Printed Name | Signature and Date