

## FINANCIAL POLICY AND INFORMED CONSENT

Thank you for selecting us to help take care of your dental health. We are committed to having your treatment be a positive experience. It is our belief that all people who entrust their oral health to us want and deserve the finest dental care that we are capable of providing. Please understand your financial obligations are considered part of your treatment. Our purpose in providing you this financial information is to acquaint you with our policy for our mutual benefit. We will give you an estimate of costs required in advance of treatment so that you can come prepared for each visit. Please read the following and sign before being seen.

1. **Full payment is due at the time of service unless prior arrangements are made.** A 5% cash courtesy will be given when accounts are paid in full on the day of service by cash or check. Other options include credit card (VISA/MasterCard/Discover) or an Extended payment plan (with prior approval) through CapitalOne Healthcare Finance or CareCredit.
2. **The following applies to those patients with insurance:**
  - a. If at your first appointment we are unable to verify your dental insurance, cannot obtain a list of benefits, or find your insurance unacceptable for assignment to our office, full payment is due at the time services are rendered.
  - b. If assignment of benefits is acceptable to us, patients are to pay their deductible and estimated co-payments at the time treatment is rendered.
  - c. While filing insurance claims is a service we extend to our patients, we must emphasize that as dental providers, our relationship is with our patients-not the insurance company. In the state of Maryland, insurance companies are required to send payment within 30 days. If a full payment is not received from your insurance carrier within 60 days, the balance becomes your responsibility and is subject to a finance charge. To avoid these fees, please authorize us to transfer this balance to your credit card:  
Visa/MasterCard/Discover: \_\_\_\_\_ expires: \_\_\_\_\_ Signature: \_\_\_\_\_
  - d. The insurance information we receive is limited to only covered procedures. We sincerely encourage you to contact your insurance company to obtain a list of procedures and limitations not covered.
  - e. Due to the uncertainties of responsibilities and relationships between your primary and secondary insurance carriers, we cannot file secondary dental claims. However, we will provide you with a detailed computer generated insurance form for you to submit for reimbursement.
3. **Minor Patients:** Must be accompanied by a parent or guardian for all appointments unless a written consent is provided. The adult accompanying the minor is responsible for the payment.
4. **Missed Appointments:** Your scheduled appointment has been reserved at your request. If this time becomes inconvenient for you, please notify our office at least 48 hours before that scheduled time or a fee may be charged. Payment of this fee may be required prior to reserving subsequent appointments.
5. **Past Due Account Fees:** There is a \$35.00 fee charged on all returned checks. Account balances older than 30 days are subject to a finance charge of 1.5% per month. Any balance older than 90 days may be forwarded to "Collections" and subject to additional fees, including, but not limited to, a collection fee (33% of the balance), attorney's fees, and court costs.
6. **Assignment of Benefits:** I assign all dental insurance benefits to which I am entitled to the extent permitted under my dental insurance policy to the Dentist. This form also authorizes the practice to submit insurance claim forms and receive payment directly from the Insurance Carrier with the notation "SIGNATURE ON FILE". I authorize my Dentist(s) to release treatment records/x-rays or any other information deemed pertinent to my insurance carrier as necessary and/or requested.
7. **Consent for treatment:** I hereby give consent to the dentist and/or his/her designee(s) for the performance of any diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I further authorize the performance of all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist(s) and mutually agreed upon by me. I understand that no guarantee or assurances have been made as to the results that may be obtained.

I have read the above policies and agree to abide by them.

\_\_\_\_\_  
Patient/Guarantor/Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date