

Greenbrier Family Dental

Financial Policy

The following is a statement of our Financial Policy, which we request you read and sign prior to your treatment.

Payment is expected when services are rendered unless prior arrangements have been made. Our office accepts: Cash, Check, Debit, American Express, Visa, Mastercard, and Discover. Also, we offer CareCredit, which is an outstanding financing option with no interest monthly payments for 6-12 months for qualified individuals.

INSURANCE: We file insurance as a courtesy to you. Our office will work diligently to ensure that your paperwork is filed accurately and promptly to assist you in receiving the maximum dental benefits that your plan allows.

Please understand that insurance reimbursement can be a long and difficult process for our office. If your insurance company has not paid its portion of your claims **within forty five (45) days, the balance will become your responsibility**. Please be aware that some, or perhaps all, of the services provided may be considered non-covered services and not considered reasonable and necessary under your dental insurance coverage. You are responsible for any co-insurance, deductibles, or non-covered services as required by your insurance. We file with hundreds of different insurance companies and cannot possibly know the benefits/limitations of all policies. As the dental plan beneficiary, it is your responsibility to know and thoroughly understand what your plan does cover.

Additionally, we will file secondary insurance for you but our practice will only use one insurance policy when calculating your portion. In many cases, secondary insurance considers what primary insurance pays to be proper compensation or they have other clause limitations that they use to determine coordination of benefits. Any subsequent payments from secondary insurance will be refunded to you or remain as a credit on your account.

***A note about insurance estimates:** We try to give you an accurate estimate of your insurance benefit based on the information we are given from you and your insurance carrier. Sometimes insurance companies do not pay what we estimate for a variety of reasons. Your insurance is a contract between you and your insurance company. We will file insurance for you as a courtesy; however, if your insurance company fails to pay what is expected from them, you are responsible for the balance. We will gladly assist you with any documentation necessary to obtain payment from your company, but we ask that you recognize that our office files insurance for your benefit and that we are not employed by the insurance company.

CREDIT CARD/DEBIT CARD POLICY: Our office requires a valid credit card or debit card number to be kept on file for your account prior to services being rendered. Your credit/debit card will only be charged if a balance remains unpaid **15 days** after it is considered **past due** by the statement you will receive. Please see the credit/debit card authorization form attached. Any subsequent payments received from insurance will be refunded to you or remain as a credit on your account.

***You may choose not to sign the credit/debit card authorization form. If you choose not to provide this information, any services rendered must be paid in full on the day they are rendered. In this case, the insurance payment will be assigned to you.**

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best comprehensive dental treatment for our patients and we charge what is usual and customary for our area. Each insurance plan has a different interpretation of a usual and customary (UCR) rate. This is an arbitrary number that your insurance company (remember each company differs) determines as a reasonable charge for each dental service. Please know that **this varies among different insurance plans**, and you are responsible for any portion that your insurance plan does not pay.

BROKEN APPOINTMENTS: When appointments are scheduled, we are allocating that time specifically for you. In order to respect your time, our time, and the time of other patients, we request that cancellations be made with at least **24 hours notice**. If less than 24 hours notice is given, we consider that a broken appointment. If you break more than 2 appointments without adequate notice, you may be dismissed from the practice at the discretion of the practice.

With less than 24 hours notice, it is nearly impossible for us to fill the time that has been allocated to you. You may be charged a **fee of \$40.00** for broken appointments for regular office visits (cleanings, exam, etc) and may be charged a **fee of \$75.00** for broken restorative appointments (fillings, crowns, etc) if adequate notice is not given.

BILLING/ FINANCE CHARGES: One (1) monthly statement will be mailed to inform you of any remaining unpaid balance on your account. If any balance remains unpaid **15 days** after it is considered past due by the statement you receive, your credit card or debit card on file will be billed for the remaining balance. You will be informed by phone call (on the number given on the authorization form) or message on answering machine prior to any charges being processed. Also, you will be notified by letter of the amount charged and will receive a receipt to show that payment was credited to your account.

A **\$30** service charge will be applied to your account for any returned check or denied credit/debit card .

COLLECTION SERVICES: After 60 days, your unpaid account may be turned over to a collection agency. Should your account be placed outside with a collection agency, **you will be responsible for any fees associated with collecting the debt**. Any patient with unpaid balances that have been forwarded to a collection agency will not receive dental services unless the balance has been paid-in-full or unless emergency care is needed.

X-RAYS: We will provide you with a copy of your x-rays upon request. You will need to sign a letter of release at the time of pick-up. Please allow **48 hours** from the time of your request. There is a **\$2.00 charge per x-ray**, that is payable at the time of pick-up.

Thank you for taking the time to read our Financial Policy. Please let us know if you have any questions. Your signature will be captured electronically and this signed policy will be scanned into your chart in our software.

_____ I accept and understand the Financial Policy, and I have received a copy of this for my records.