We are committed to deliver comprehensive dental care to our patients, using state-of-the-art technology and the highest quality materials available today. We always recommend treatment based upon dental needs, and not based on insurance coverage, which can be Inadequate with some dental plans.

We believe dental insurance is a benefit used to assist the patient, not dictate necessary treatment. This agreement is to inform our patients of the financial policies currently in affect for all Dental Arts practices:

DENTAL INSURANCE

- Knowledge of covered benefits as well as amounts, limitations, exclusions, waiting periods, etc. are exclusively the patient's responsibility.
- Our office will provide all necessary documentation supportive of recommended treatment plans, in order to prove rationale and reasons for medical necessity.
- Completing Insurance-forms for our patients Is a courtesy offered to help facilitate timely payment from Insurance companies. This process does not eliminate the patient's financial obligation. We are happy to help submit dental claims on behalf of our patients, but we do not accept responsibility for the outcome of the transaction.
- Assignment of benefits from insurance companies are accepted by our office, but the terms of agreement regarding dental benefits is between the insured (beneficiary), the employer, and the insurer (insurance company). Although we may estimate insurance benefits, we are not responsible for their accuracy.
- Not all dental services provided in our office represent covered benefits under an individual plan, therefore payment for treatment cannot be guaranteed. If a claim Is denied, full payment becomes the patient's responsibility at the time services are rendered. Accepting our services indicates the patient's acceptance of such responsibility.
- Our practice will not enter into a dispute with any insurance company over claims. Once complete documentation Is submitted to the insurance carrier, it is the responsibility of the insured to resolve any type of dispute over payments to be rendered to our office.
- Insurance payments are typically received within 30-60 business days from the time of billing. All charges not paid by an insurance company become the patient's responsibility regardless of reason for nonpayment.

PAYMENT METHODS: CASH / CHECK / CREDIT CARD

- Returned checks and balances older than 60 days will be subjected to collection fees and finance charges at the rate of 1.75% per month (21% annual rate)
- No post-dated checks are accepted

PAYMENT FOR TREATMENT RENDERED

- All charges Incurred for any treatment provided in our offices are the patient's responsibility regardless of Insurance coverage.
- The co-payment is the portion of the cost of the treatment not honored by the dental insurance. Timely payment of the financial responsibility helps maintain administrative costs and dental fees low.
- As we work with our patients to deliver optimal oral and dental health, we ask that the estimated co-payment for treatment be paid at the time of service.
- Our practice accepts cash, personal checks, MasterCard, Visa, Discover and American Express.
- The estimated co-payment may be adjusted after completion of treatment, depending upon the final reconciliation of insurance payments.
- Reimbursements will be issued by check, within 30 days of the final reconciliation of payments

PAYMENT PLANS

- We understand temporary financial problems which may affect timely payment of balance. In those situations, we encourage to immediately communicate any such problems, so we may discuss available alternatives in managing your account.
- We are pleased to offer Care Credit, a financial company which helps devise individual payment plans. This allows completion of dental work without delay and helps fulfill financial responsibility in monthly installments. Care Credit is only applicable for treatment plans exceeding $300. Citibank and KeyBank offer similar benefits with no minimum amount. Applications may be submitted in the office or online at www.carecredit.com. Approval may be obtained within ten minutes.

OVERDUE BALANCE

- Accounts with unpaid balance past 90 days are submitted to a collection agency.
- Costs incurred in debt collection include: additional Interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with debt collection.
- Above referenced expenses are the responsibility of the patient

DENTAL RECORDS

- Original records including radiographs are the property of this office.
- Copy of dental records or radiographs will be provided **upon written request**, for a nominal fee

OVERDUE BALANCE

- Original records including radiographs are the property of this office.
- Copy of dental records or radiographs will be provided **upon written request**, for a nominal fee

CANCELLATIONS AND RESCHEDULING DENTAL VISITS

- Prior notice of 24 business hours is required to cancel and reschedule existing visits.
- A $50 charge will be added to the patient's account for missed visits if no notice is received

STATEMENT of RELEASE OF INFORMATION and ASSIGNMENT of BENEFITS

I understand it is my responsibility to know the terms of my dental insurance. In compliance with the above stated terms, I agree to the following:

___ I read the above stipulations and agree to pay Ellet Dental Arts in full without regard to insurance coverage, whether I sign as a responsible party or as a patient

___ I agree to pay Interest at the rate of 21 % APT on any balance over 90 days from the date of service.

___ I agree to pay any collection fees as stated above should these means of collection become required.

___ I am providing this office with complete and accurate billing information, including but not limited to current insurance card and pertinent authorization numbers If applicable.

___ I am responsible for all visits and procedures not properly authorized.

___ I will pay all applicable co-pays and outstanding patient balances as they become due.

___ I give my consent to provide dental care and treatment to the below name patients as deemed necessary and appropriate in diagnosing or treating the stated dental conditions.

______________________________ Patient Name (print)

______________________________ Patient Name (signature)

______________________________ DATE