

Patient Financial Policy

Office and Financial Policies

Thank you for choosing Oak Family Dental as your dental provider. We are committed to building a successful dentist-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is part of that relationship. This policy is designed to answer questions you may have about our fees, policies, or your responsibilities. In order to properly bill you and/or your insurance company we must maintain the most updated patient demographic information (i.e. address, name, insurance information, etc). It is your responsibility to notify our office of any patient information changes when they occur.

Accepted Methods of Payment: We accept cash, checks, all major credit cards and Care Credit. We do not accept post dated checks. A \$25 charge will be added to your account for any check returned by your bank for any reason.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage, or patients covered by insurance plans we do not participate with. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Full payment will be due at the time of service. We do offer convenient no interest financing. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

Insurance: Insurance is a contract between you and your insurance company. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information, as well as, any change of insurance information. You must also present a picture ID and your insurance cards at the time of your appointment. Failure to provide complete insurance information may result in patient responsibility for the entire bill. **Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.** You agree to pay any portion of the charges not covered by insurance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Co-Pay: With insurance plans where we have agreed to participate in the network as a provider, your carrier requires that all co-pay be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.

Scheduling Appointments: Appointments, where treatment is valued at or above \$500.00, a \$200.00 deposit is required to schedule. This deposit goes towards payment for the treatment rendered and serves to reserve an extended period required for your treatment.

Canceled Appointments: If you are unable to keep your scheduled appointment, please call our office within 1 business day to reschedule. There will be no penalties for appointments canceled with 1 business day notification. Patients will be allowed one missed appointment per year without notification, with no charge. Additional missed appointments will be assessed a \$25.00 charge that will be applied before patient can schedule additional appointments.

Billing: There should only be a balance on an account if insurance does not pay or the estimated balance paid by the insurance is different than we estimated. In this case you will receive a bill from our office, if you do not have a credit card on file. Please pay within 15 days. Statements are mailed out if there is an outstanding balance on your account. If your account is overdue we may attempt to contact you by phone. If no resolution can be made, the account may be sent to an outside collection agency, or attorney and you may be discharged from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collection costs including attorney fees and court costs. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

I agree to abide by Oak Family Dental's "Patient Financial Policy." I understand that this policy may be amended and/or updated from time to time and that I may receive a copy of the updated policy upon request. I also agree to be responsible for any collection costs including attorney fees and court costs.

X

Patient/Legal Guardian

Date