PRECISION EXCELLENCE QUALITY
MJM

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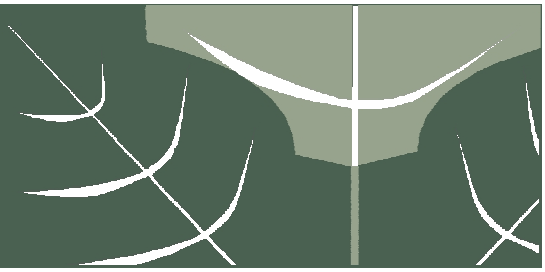

# FINANCIAL POLICY

In order to facilitate access to the very best health care possible, you may choose from any of the following payment methods:

a) **Pay As You Go** - You may choose to pay your obligation for each visit at the time of service. We accept cash, personal check, Visa, Mastercard, American E xpress, or up to 12-months interest free financing (see item C.)

b) **Up to 12 months Interest Free Financing** - (with loan approval from Care credit.) The office will pay for 3, 6, or up to 12 months interest (depending on the amount charged) when your treatment is paid-in-full using Care credit. The application is very brief, and their response time is almost immediate. Please ask for more details.

As a condition of treatment in this office, financial arrangements must be made in advance of any treatment rendered. The total cost of treatment is the financial responsibility of each patient. As a courtesy, we will initially ask you for only the estimated portion of your bill. Please understand that this is only an estimate, and is based solely upon the information given to us by you, or your Insurance Company. A ll accounts with a balance over 90 days will be charged a finance charge of 1.75 per month. Any account in default, past due balance over 120 days, will be referred to our collection agency. A ll associated fees with the collection process will be charged to the person financially responsible for such account.

As a courtesy to our patients, we will be happy to complete and forward insurance forms relative to dental treatment, and we will do our best to help you derive the maximum benefits available. However, in order to avoid misunderstandings, please read carefully and understand the following policies in regard to dental insurance benefits:

Our professional treatment is rendered to you, not the insurance company. You are responsible to us for the obligation of payment for treatment. To serve and assist you in utilizing your dental insurance, this office will accept your assignment of benefits. It is your responsibility to provide us with insurance forms assigning payment to this office and you are responsible for balances not covered by your policy on the day of service.

Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount your plan will pay or the treatments your plan will cover, you should refer these questions to your employer. We are not responsible for determining what your benefits are to be.

Some policies request a “pre-authorization” before treatment is begun. We will submit a treatment plan for review by your insurance company if this is a requirement.

Please remember that dental insurance is designed to assist people to obtain dental care and rarely covers more than 1/3 to ½ of the total cost of service. There may be a deductible, a co-insurance factor, and a yearly maximum to consider. Most policies cover what they consider a “usual and customary fee.” These fees are arbitrarily set by the insurance company, and are not always the same as the fees that may be charged in this office.

The final obligation for dental treatment is between the patient and our office. The insurance company is responsible to the patient, and not to our office. We will assist in any way that we can, but once the carrier has paid their portion of the claim submitted, any difference will be due by the patient upon receipt of our statement. If for any reason we are not in receipt of the insurance carrier’s payment 90 days after the claim is submitted, the patient will assume full responsibility of the bill. Our office cannot be responsible if your insurance company denies payment on any claims as our responsibility is to provide the highest standard of care and not only what the insurance company allows.

# MISSED APPOINTMENTS

Anytime you are unable to keep a scheduled appointment please contact the office immediately. We ask for a 48-hour notice for cancellations. We realize that emergencies do occur and we will be flexible under those circumstances. A fee of $65.00 will be charged per hour that was reserved for your appointment.

I have read and understand the office policy stated above and agree to accept responsibility as described. i also agree to accept this responsibility for the duration of my care at Dr. Miller’s office.

Signature _____

Date _____/ _____/ _____