Joseph & Joseph Dental

515 East Mill Street, Plymouth WI

(920) 893-5131

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy.

Payment is due at the time service is provided: We accept cash, personal checks, debit card, money orders, Visa, Mastercard and Discover. Outside financing is available through Care Credit upon request and approval. Returned checks will be subject to a $25.00 fee, and any future checks will not be accepted thereafter. We offer an 8% courtesy, for treatment that is paid in full, on the date of service, with cash or check and a 5% courtesy paid with credit card. Patients that receive the checks from the insurance company are required to provide us with a credit card with authorization to bill your account for the amount paid to you by the insurance company.

Dental Insurance: Our office is out-of-network (non-participating) for all insurance companies. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. It is **your responsibility** to ensure that the insurance information we have on file is accurate. We have no way of knowing when/if your insurance coverage changes. As a courtesy to you we will help you process all your insurance claims. However, it is **your obligation** to familiarize yourself with your insurance coverage as benefits vary and not all services are covered. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. We ask that you pay the deductible and co-payments, which is the **estimated** amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Dental Insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, from the date of service, the unpaid balance becomes our responsibility.

Usual and Customary Rates: Frequently, insurance companies state that the reimbursement was reduced because the dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company. A statement such as this gives the impression that any fee greater than the amount paid by the insurance is unreasonable or well above what most dentists in the area charge for a service. This can be very misleading and simply not accurate. Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processed. The insurance company then takes this data and chooses a level they call the

"allowable" fees are set by the insurance company so they can make a net 20%-30% profit. Our office is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. You are responsible for the payment regardless of any insurance company's determination of usual and customary rates.

Treatment Plan: Please understand that we will provide a treatment plan estimate to you however it is not a guarantee that your insurance will pay exactly as estimates. Your insurance company and your plan benefits ultimately determine the amount paid. Treatments proposed may change due to situations requiring additional treatments.

Finance Charge: We reserve the right to charge interest in the amount of 1.0% per month (12% annually). All balances older than 90 days will be subject to this rate.

Separated & Divorced Couples with Dependent Children: We are not a party to the court order therefore it is the policy of this office to bill the parent that brings the children in for their dental treatment.

Cancellation & Late Policy: Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We understand that emergencies may arise that preclude you from keeping an appointment, but as our office strives to treat patients in a timely manner, we expect the courtesy to be returned. For cancellations we require 24 hours advanced notice, to avoid a possible cancellation fee due to the inconvenience caused to the office. Your early cancellations will give another patient the opportunity to have access to timely dental care. An answering machine is available for messages left after business hours.

Missed Appointments: Missed appointments are very disruptive to the schedule and do not allow access to care for other patients desiring appointments. A failure to present at the time of a scheduled appointment will be recorded in the patients chart and we reserve the right to assess a $50.00 broken appointment fee. Patients with frequent no-shows or cancellations may be dismissed from the practice.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.

Consent: I have read, understand and agree to the above terms and conditions and have had any and all questions answered to my satisfaction. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carriers(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

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Print name of patient or responsible party

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Signature of patient or responsible party Date