Financial Policy

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It is our goal to provide you with the finest quality dental care available at a cost that is both fair and reasonable. In order to achieve this goal, we need your cooperation and your understanding of our payment policy. The following is a statement of our Financial Policy which we require you to read and sign. Our office accepts cash, personal checks (no third party checks), Visa, MasterCard, Discover Card and CareCredit for your convenience. It is your responsibility to provide accurate and current contact information (address/phone) and insurance coverage information. Failure to do so is a conflict of this financial agreement.

- **Self-Pay:** Payment is due in full at the time services are rendered. IF you have no traditional dental insurance you are considered self-pay.
- **Reimbursement Insurances:** Reimbursement insurances pay you, the patient, directly and are considered as **Self Pay** accounts (see above) as a courtesy we will submit your claim to your insurance carrier on your behalf.
- **Traditional Dental Insurance:** Your dental insurance is a contract between **you and your insurance carrier**. As a courtesy to your patients we agree to file your insurance claims, however we **DO NOT** assume responsibility to know the full benefits of your individual plan. We recommend that you question your insurance company regarding your benefits and limitations of your coverage. Do not assume that all treatment received in the dental office is covered by your plan. Of office is unable to file claims for patients who do not provide us with current, accurate insurance information. In the event you are unable to provide us with your confirmable insurance information (ID and group numbers, mailing address) your account will be treated as SELF PAY (see self-pay above). It is your responsibility to provide us with your current insurance information. Please inform us immediately of any changes in coverage. Charges not paid by your insurance company within 90 days of claim submission will become due and payable by you.
- **Participating Provider:** WE participate with MOST Delta Dental, United Concordia, United Concordia GRID, Cigna, and Blue Cross Dental insurance plans. ***Although we participate with these plans you will have a co pay, deductible or co-insurance due this office.*** Collection of these deductibles and co pays is an insurance requirement for which we are under contract to bill and collect these fees, they cannot be waived. Failure to pay these charges may result in reposting of the contractual deduction to your account as permitted by our contract with your insurance company.
- **Predetermined Benefits:** Predetermination of benefits is ***NOT*** a guarantee of payment by your insurance company. If the submitted predetermined claim is denied by your insurance company or an adjustment in benefits is conveyed, you will be held responsible for payment of the service (s).
- **Denied Services:** In the event your insurance company determines a service to be "***Not Covered***, you will be held responsible for payment. *It is your responsibility to understand your insurance benefits and limitations.*
- **Medical Access:** In order for us to accept and file PA Medical ACCESS (Plus) and the other insurance administrators of the PA Medicaid Programs, you must present your current valid insurance card at each visit; any co pay is due at the time of service. Co pays for this insurance are assessed on patients 18 years of age or older and due on the date of service unless you have been rendered "Unable to Pay" by the PA. Dept. of Public Welfare and have supplied our office with the proper documentation.
- **Divorce:** The responsibility for payment of services rendered to dependent children with divorced/separated parents rests with the ***Presenting Parent*** (Parent seeking treatment for dependent children). If there is a court ordered responsibility of judgment decree that requires the other parent to pay part or all of the treatment

costs, it is the authorizing (presenting) parent's responsibility to collect payment from the other parent. It is also the authorizing (presenting) parent's responsibility to provide us with any insurance information that we may require to file an insurance claim on the dependents behalf.

- **Monthly Statement:** If there is a balance due on your account this office will issue a statement which will indicate the balance due as of that date. The balance is due ***"In Full"*** by the due date listed on the statement. If payment is not received in this office within 30 days it is considered delinquent. An Administrative Rebilling Fee (currently $5) will be added to any subsequent statements issued by this office on unpaid balances which is due and payable to this office. We reserve the right to dismiss you, and/or your family members listed on your account, from the practice if your account is not maintained in a fair equitable manner.
- **Past Due Accounts:** If your balance becomes past due or delinquent, we will take the necessary steps to collect this debt. If your account is referred to a collection agency, you agree to pay us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees, which we incur in such collection efforts. In case of suit in a court of law you agree the venue shall be in the county in which your dental treatment was delivered. If your account is submitted to an attorney or collection agency, the fact that you received treatment in our office may become a matter of public record and will result in a ***Waiver of Confidentiality".***
- **Missed Appointment Fee:** Our office reserves the right to charge a fee for missed or canceled appointments. If a patient fails to show, does not arrive on time, or does not cancel 24 hours prior to the scheduled time a fee of $25 **per scheduled patient** will be charged based on the patient's scheduling history. If after 3 instances of failure to show or failure to cancel within 24 hours of your appointment this office reserves the right to sever our Doctor/Patient relationship and dismiss you from our practice.
- **Returned Check Fee:** A fee of $35 will be charged for checks returned from the bank for ANY reason. We reserve the right to submit your information to the legal authorities if a check is written on a closed account, a forged check or a check written without sufficient funds as these are considered crimes in the state of Pennsylvania. If we received a returned check on your account any and all future services are payable by credit card or cash.
- **After Hours Call:** Dr. Steele will be available for "after hour emergency call" for "Current patients of record only". In the event Dr. Steele is unavailable an alternate dentist will be on call for this office and fees will be charged from the attending dentist's office. An "After Hour Call Fee" will be charged for this service