BUEHNER FAMILY DENTAL CARE

Financial Policy

We would like to thank you for choosing us as your dental provider. We are committed to providing you with quality dental care and a clear understanding of our financial policy. Please understand that the payment of your bill is considered a part of your treatment. This is a breakdown of our policy which we require you read and sign prior to treatment. All patients must also complete a Patient Information/Health History and an Acknowledgement of Receipt of Notice of Privacy Practices before being seen by the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE UNLESS COVERED BY PARTICIPATING INSURANCE CARRIER. WE WILL GLADLY ACCEPT MASTERCARD, VISA, DISCOVER, DEBIT CARDS, CASH OR PERSONAL CHECK. WE ALSO OFFER PAYMENT PLANS FOR TREATMENT AT OUR DISCRESSION.

Regarding Insurance: **All charges you incur at each dental visit 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. Your insurance policy is a contract between you, your employer, and the insurance company. It is ultimately the patient's responsibility to know details of your dental benefits. It is also the patient's responsibility to verify if the practice is in or out of network with his or her insurance policy and to be aware of your maximum allowance. As a courtesy, it is our staff's only responsibility to assist patients in filing out and submitting the insurance claim. Patients with dental insurance will be responsible to pay the estimated insurance copayment of a procedural allowance and deductible at the beginning of treatment. As well as, authorize the assignment of the insurance benefits to us. After insurance benefits are received, if there is an overpayment, a refund will be sent to you. **If there is an additional amount due, we will send a statement balance. If it is a non participating insurance, any charges incurred in our office are your responsibility at time of service**; we will still file your insurance claim, and will mark the payment as payable to you directly. Your insurance claim can **ONLY** be submitted if we are supplied with the proper insurance information from you (i.e.: **insurance company address and phone number, subscriber's identification number and group number**). It is your responsibility to make sure your policy is active on your date of service. If your insurance company has not paid your claim within 45 days please contact your insurance company. Your dental plan may not cover certain procedures; however this does not mean these treatments are unnecessary. If you have questions regarding your dental plan, or a problem with a reimbursement level, contact your employer or insurance company. Our staff may be able to explain dental plan issues to you. But, it is your responsibility to be educated on the levels of coverage provided by your plan. **Patient's Initials: _____**

Usual and Customary Rates: Our practice is committed to providing good treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what is an appropriate charge.

Missed appointments: The first missed appointment will generate a letter outlining our policy.
The second missed appointment (within a 12 month period) will generate a charge of $35, plus a warning letter.
The third missed appointment (within a 12 month period) will generate a second charge of $50 and may cause dismissal from our practice.

Returned Checks: Patients will be charged $50 for each returned check, and are responsible for the amount owed.

Accounts: After 60 days from the date of service a 35% collection fee will be added to your account if there has been no attempt to make payment or set up a payment schedule. All accounts delinquent over 90 days and without a payment schedule will be turned over to a collection agency for further collection procedures. All past due accounts must be paid in full before you can schedule another appointment.

I have read and understand the financial policy as explained herein and agree to be bound by its terms. I understand that the office reserves the right to amend this policy at any time.

_____ _____

Signature of Patient or Responsible Party Date