CRESCENT DENTAL
FINANCIAL OFFICE POLICY

In order to provide the best possible care and service to our patients, and because dental insurance companies have become increasingly difficult to work with, we have established the following Financial Office Policy, which clarifies your financial responsibilities to us in keeping your account current for services rendered to you and any family members whether you have insurance coverage or not, and does not place us in a constant confrontational role. From experience we have learned that there is a big difference in what coverage you think or have been told you have and what the companies actually pay for you.

PAYMENTS

- ***All payments , and/or Estimated INSURANCE Co-payments are required to be paid on the day services are rendered.***
- ***We accept cash, personal checks, debit cards, and all major credit cards.***
- ***Outside financing is available through Care Credit for those who apply and qualify and need a payment plan.***
- ***All billing statements are due upon receipt of those statements to prevent further collection activity.***
- ***Please note that we as caregivers cannot and will not enter into disputes over Family Account balances due between husband and wives and their dependents regardless of any court orders, and/or who the insurance policy holder is. We appreciate your understanding in this matter.***

MINOR PATIENTS

- ***Minor patients under 18 years of age MUST be accompanied by a legal parent or guardian.***
- ***The adult accompanying the minor to his or her appointment is responsible for payment for any services rendered.***

FINANCIAL CHARGES

- ***All returned checks are subject to a $30 fee.***
- ***In the event that it becomes necessary for our office to enlist a collection agency and/or legal assistance to resolve any past due account balances you will be responsible for any collection and/or legal charges incurred.***

FAILED APPOINTMENTS

- ***Please consider your scheduled appointments carefully. We require a 24 hour cancellation notice.***
- ***With the exception of a TRUE EMERGENCY, if you fail to keep your appointment, and/or cancel with less than a 24 hour notice, we will charge your account a $50 broken appointment fee.***
- ***If you repeatedly miss scheduled appointments, you may be asked to seek treatment elsewhere.***
- ***As a COURTESY to you, we make every attempt to confirm your appointment in advance. However, it is YOUR RESPONSIBILITY for knowing and keeping scheduled appointments for you and your family members.***
- ***We ask that you return our REMINDER calls with a confirmation of your appointment. We provide voicemail service for your convenience in leaving us a message during and after business hours.***

CHANGES IN ACCOUNT INFORMATION

- ***Accurate, up-to-date information is YOUR RESPONSIBILITY.***
- ***Please call our office with Any changes in Name, Address, Phone numbers, Family status, Employment, and especially any changes in Dental Benefits.***

REFUNDS

- ***Patient refunds are issued by our Practice Manager once a month and mailed to you once all insurance claims have been processed and all insurance payments have been posted for all family members on your account.***
- ***If you want us to leave a credit balance on your account to use for upcoming appointments and/or treatment, please notify the front desk so we can make a note of this.***

REGARDING INSURANCE

In order for us to honor your dental benefit plan the following requirements must be met:

- ***You MUST provide us with current and accurate insurance identification information.***
- ***Your current benefits have been verified by a member of our staff.***

INSURANCE VERIFICATION

- ***Any changes to your insurance company MUST be provided to us PRIOR to any scheduled appointment for verification. Your new insurance will not be accepted without this prior verification.***
- ***We must be given adequate time to verify dental coverage. If adequate time is not available, or if it is a time other than normal business hours when insurance companies are closed, you will be responsible for all charges when rendered until verification is achieved.***

CO-INSURANCE, CO-PAYS AND DEDUCTIBLES

- ***Our experienced staff will ESTIMATE your deductible and the portion of your charges not covered by your dental plan and they must be paid at the time services are rendered. If you refuse to pay your estimated co-pay, you must pay up front, in full, for all services rendered and we will provide you with the information you need to file your own claim and be reimbursed directly from your insurance company. These estimates will be based on your Primary Insurance benefits.***
- ***Our estimates are based on the information provided to us by an insurance company representative via phone or fax, but is not a guarantee of payment or approval for the treatment rendered. The final payment is decided upon by your insurance company and therefore subject to change.***
- ***If the insurance company pays more than the estimated amount, a refund check will be issued to you once all your and your family's claims have been processed and all payments posted.***
- ***If the insurance company pays less than the estimated amount, a statement will be sent to you and is due upon receipt of that statement.***

PRE-TREATMENT ESTIMATES

- ***We will submit a pre-treatment estimate on your behalf at your request in the event of a complicated treatment plan. However, these estimates are not a binding contract, and do not guarantee that your insurance company will pay exactly as estimated. Your plan benefits at the time you have the treatment done ultimately determine the amount paid.***

IMPORTANT INSURANCE INFORMATION FOR YOU TO REMEMBER

- ***We verify your dental benefits as a COURTESY to you, not as an Obligation, to assist you in optimizing those benefits while minimizing your concerns about your out of pocket expenses if you accept the doctor's recommended treatment plan. However, you are responsible for knowing your plan's coverage, exclusions, waiting periods, maximums, non-covered services, downgrades on posterior restorations and crowns, frequency limitations to mention a few. It is your responsibility to contact your insurance company with any questions you may have regarding your coverage.***
- ***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 carrier. Your insurance policy is a contract between you, your employer, and the dental plan carrier.***
- ***For those plans with which we have an agreement, we will post any applicable adjustments, per our contractual obligations, to your account when the insurance payment is received.***
- ***We cannot leave an open balance on your account indefinitely waiting for an insurance company to make a payment. We will cooperate in providing them with any requests for additional information they may require to process a claim. However, if we do not receive payment after 90 days, you will have to pay us directly and settle with your insurance company after the fact.***
- ***If at any time we receive payment from your insurance company after you have paid us, you will be issued a refund check.***
- ***If a balance occurs on your account due to inaccurate insurance information, termination of insurance on file, the balance for those charges immediately become your responsibility. Accurate, up-to-date information is YOUR RESPONSIBILITY.***
- ***If you fail to notify us in the beginning that you have or have had Secondary insurance for past claims, you forfeit those benefits, but we will file the secondary insurance for claims from that point forward.***
  Please note that having secondary insurance does not mean that you will never have a balance.

____To help you further understand your insurance benefits, we have printed out a list of terms from a typical insurance policy, but your particular plan coverage may be higher or lower. Please initial that you have received a copy of this printout.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL OFFICE POLICY. I ACKNOWLEDGE THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED FROM SERVICES RENDERED BY Dr Kavita Ghai, DDS.

PRINT NAME_____(Patient/Parent/or Legal Guardian)

Signature_____ DATE_____