

BARNWELL FAMILY DENTISTRY

FINANCIAL POLICY

Rev. 01/22/2018

Thank you for choosing us as your dental health care provider. We appreciate the opportunity to serve you. Our philosophy is to recommend treatment that helps you achieve optimal oral health. Our recommendations are based on what is in your best interest, not on what your insurance company will pay or how much benefit you have left. We also believe that a clear understanding of financial obligations and options in advance helps relieve some of the anxiety associated with dental visits, and helps establish the foundation for mutual trust.

The following are statements of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our registration forms before any treatment can be provided.

FULL PAYMENT IS DUE AT TIME OF SERVICE

WE ACCEPT CASH, CHECKS, VISA®, MASTERCARD®, DISCOVER®, AND DEBIT CARDS. WE ALSO ACCEPT CARE CREDIT®.

Patients without insurance coverage need to know...

The fee for the treatment rendered must be paid in full on the day of service, unless prior arrangements are authorized by Dr. Sáenz.

Patients with insurance coverage need to know...

Patients need to provide us with all pertinent dental insurance information prior to any treatment. The estimated patient co-pay and deductible for the treatment rendered must be paid in full on the day of service.

Your insurance coverage is a contract between your employer and your insurance company. Benefits and coverage vary significantly from plan to plan depending on what your employer has agreed to with the insurer. Keep in mind that insurance is not designed to provide 100% benefit, but rather is meant to aid in the cost of dental treatment. Please understand that regardless of any insurance company's arbitrary determination of what is usual and customary, you are ultimately responsible for all fees generated by your treatment. We are in network with Delta Dental Premier and Blue Cross Blue Shield Dental Plus. We are also a SC **Medicaid** Provider.

If Dr. Sáenz has treatment recommendations for you, you will receive an itemized list of the recommended treatment. This list will contain an estimate of the fees for the recommended treatment. **Please be advised that this is only an estimate.** The actual amount paid may vary depending on what your insurance company will cover or changes to your treatment. Treatment estimates are valid for 1 (one) year, after which time new fee structures may apply.

As a courtesy to our patients, we are happy to submit all claims for you by filing electronically on the day services are rendered. We will do everything we can to secure payment from your insurance company. However, if your insurance company has not paid your account in full within 45 (forty-five) days, you will be asked to pay the balance. Any balance on your statement is due and payable when statement is issued, and is overdue if not paid by thirty (30) days after statement date. We will promptly refund to you any insurance payments we receive if you have already paid the balance of your account.

Payments and Plans: We understand that people have different needs in fulfilling their financial obligations. Therefore, we provide different payment options.

- We accept cash, checks, Visa®, MasterCard®, Discover®, and debit cards.

- We also offer Care Credit®, a healthcare financing program that offers interest-free payment plans of 6 or 12 months upon approval.
- We offer a courtesy discount of 5% for all uninsured, non-QDP treatments over \$1,000 paid in full by cash or check.
- We also offer an in-house dental savings plan called Quality Dental Plan (QDP). We'll be happy to answer any questions you might have.

24 (twenty-four) hours notice is required for rescheduling appointments.

Our practice is dedicated to quality care and exceptional service. Dr. Sáenz and team spend extensive time in preparation for your visit. Please be considerate. Help us serve you better by keeping your appointment. Broken and missed appointments create scheduling problems for our team, increase the cost of providing quality care, and affect our ability to provide care for other patients. If you find that you must change your appointment, we require 24 (twenty-four) hours notice so that we may make every effort to serve other patients. If proper notice is not received, a \$30 fee may be charged to your credit card on file. If 2 (two) broken or no-show appointments occur within a 12 (twelve) month period, we reserve the right to require full payment prior to any future appointments.

Treatment appointments of \$2,000 or greater

We reserve the right to require a 10% down payment towards treatment of \$2,000 or greater to reserve appointment. If patient fails to provide 24 (twenty-four) hours notice, down payment may be forfeited and patient may be asked to pay in full prior to rescheduling.

Past Due Accounts: If prior arrangements have not been made and authorized by Dr. Sáenz and your account becomes past due over 75 (seventy-five) days, it will be considered delinquent and we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs that are incurred. Please be advised that this could affect your credit rating. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees that we incur, plus all the court costs.

Returned Checks: There is a fee (currently \$25) for any returned checks.

Insurance Release: You authorize Dr. Sáenz to release any necessary information requested by your insurance carrier and authorize payment directly to Dr. Sáenz for any benefits available under your insurance plan.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

This is an agreement between Dr. Sáenz, as creditor, and the Patient/Debtor named on this form. By executing this agreement, you consent to treatment by Dr. Sáenz and his staff and agree to pay for all services that are received.

Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____

Responsible Party: _____

Signature: _____

Date: _____