Financial Policy

We would like to thank you for choosing our office for your dental care.
This policy is in effect to familiarize you with our financial expectations from our patients. If at any time you have any questions regarding any treatment fee or service, please discuss them with us promptly and frankly. We will make every effort to avoid a misunderstanding, to rectify an injustice, or to preserve a friendship. This is an agreement between Eagle Run West Dental Group and the Patient/Debtor named on this form, effective on the date signed.

1. Eagle Run West Dental accepts several forms of payment:

   Cash, Check, Debit Cards, MasterCard, Visa, Discover, and American Express

2. ***Dental Insurance***: **Our services are rendered to a person, not an insurance company. We are not a provider for any insurance company, thus you will be responsible for any fees your insurance does not cover**. It is our courtesy service to you to submit all claims within 24 hours, with the necessary documentation and correct coding. Our goal is to assist you in maximizing your dental coverage. We will work with you to understand your policy exclusions, deductibles, and required co-payments. You must realize we are not a party to the contract between you and your insurance company. Insurance companies restrict payments based on the premium paid for the insurance, NOT OUR FEES. Our office is proud to offer the quality of care we provide at such reasonable costs.

3. ***Financial Arrangements:*** In the event you are not able to afford all of your treatment in one payment, we offer alternate arrangements:

   A) *Care Credit*: This is an outside financing company that provides our patients with an interest free loan for dental treatment with a very small initial fee based on the amount of the loan. For treatment of $300.00 or less, an interest free period of 6 months is provided with a 5.9% processing fee. For treatment greater than $300, an interest free period of 12-18 months is provided with a 9.9% - 13.5% processing fee, respectively. There are also extended payment plans from 24-60 months with a 14.9% APR, in addition to the 5.9% processing fee. This company is contacted by you via the Internet or phone and a short application is required. After the interest free period, Care Credit does calculate the loan with a standard credit card interest rate, so it is in your best interest to pay it off within the interest free time period.

   B) *Post Dated Checks/Credit Cards:* Our office will offer you credit if you are able to pay off your balance within 90-days. We will work with you to calculate the frequency and dollar amount of each payment required to pay off your balance. You may either leave checks for those calculated amounts to be posted at a later date or you may sign a credit card agreement that specifies the dates and amounts your card will be charged until the account is paid. If you need longer than 90-days and/or have a special financial circumstance, our office will work with you to arrange an alternate extended payment plan *at our discretion.*

4. ***Workers Compensation, Personal Injury, MVA***: As a courtesy to our patients, our office will file worker's compensation, personal injury, or motor vehicle accident claims with the correct coding and documentation. However, due to the length of time involved in processing these types of claims, YOU are required to pay for the treatment fees at the time of service (financial arrangements are available). Any reimbursement we receive for these claims will immediately be returned to you.

5. ***Divorce:*** In the case of divorce, the party responsible for the account prior to the divorce remains the responsible party. After the divorce, *the parent authorizing treatment* will be responsible for those charges. Any reimbursement from a spouse not present is handled between the two separated parties.

6. ***Missed Appointment Fee:*** The second time a patient does not show up for an appointment, or cancels with less than 24 hours notice, a $25.00 fee will be charged. This fee must be paid before a new appointment will be made. In the event the fee is not paid within 60 days, your "Credit Card on File" will be charged.

7. ***Returned Checks:*** There is a fee (currently $25.00) for any checks returned by the bank.

8. ***Transferring Records:*** Due to the HIPAA Policy established on October 16, 2002, you are required to sign a release form authorizing the transfer of your records and/or x-rays to another office. A fee of $35.00 may apply.

9. ***Material Deposits:*** For treatment involving outside lab fees – such as crowns, dentures, bridges, splints, etc. – a minimum required down payment will be calculated to cover costs of the outside lab. Treatment will not be completed until the balance is paid in full (i.e. crowns will not be cemented, bridges will not be seated, dentures and splints will not be tried in).

10. ***Past Due Accounts/Finance Charges*:** If you have a balance on your account, we will send you a monthly statement showing all current charges and payments. A finance charge will be imposed on each item of your account that has not been paid within thirty (30) days of the time the item was added to your account. The FINANCE CHARGE will be computed at the rate of 1.33% per month or an ANNUAL PERCENTAGE RATE of 16%. If an account has had no payment after ninety (90) days, and the responsible party has not contacted us to attempt a financial arrangement, it is considered delinquent and we are required to release all account information to a collection agency. At this point, we are no longer in control of the account and are unable to remove it from collections. It will show up on your credit report! Any appointment made for a patient on an account that has been sent to collections will be made on a CASH ONLY basis.

11. ***Credit Card on File:*** To keep our fees low, it is imperative that we keep ALL patient accounts from having past due balances. In order to do this, we require a "Credit Card on file" for all patients. ***It is to be used ONLY in the event your account is not paid within 60 days from the first statement.*** A statement will not be generated until all insurance claims are settled. Any alternate financial agreements made with our office supersede this policy unless you fail to comply with those alternate arrangements.

I authorize Dr. Wilson to keep my signature on file AND to charge my credit card with the balance of charges (after insurance pays if applicable) 60 days after the first statement has been generated, not to exceed $_____ for all visits. This agreement is good for one year after the date signed and may only be cancelled by written request.

_____ Date _____

Responsible Party Signature

Family Members covered by this agreement:

_____

Credit Card on file **REQUIRED**

_____ - _____ - _____ - _____ Exp Date _____ Card ID*_____

*Look in the signature box on the back of card. The last three digits are the ID.

Please Circle: MC VISA DISC AMEX CARE CREDIT

I choose not to leave my credit card. In doing so I will pay the estimate of my portion at the time of service and/or I will wait for an insurance pre-approval before scheduling treatment. (Initial)_____

Patient's Name: _____

Responsible Party (if not Patient): _____

Signature of Responsible Party: _____ Date: _____

I acknowledge that I have read and understand this Financial Policy (initials) _____

A copy of this policy may be requested at any time.