PATIENT RESPONSIBILITY AGREEMENT and INSURANCE POLICY

We would like to take this opportunity to Welcome you to our practice and assure you that we will do our utmost to provide you or your child with the best possible care. The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to you/your child's first visit.

Please Note: Payment is due at the time service is provided. Our office accepts cash, check and credit cards including Mastercard, Visa, Discover, American Express and CareCredit. Outstanding financing is available upon request and approval.

Diagnostics, like x-rays, and treatment are rendered based on standards of care adopted by the doctor. These may conflict with insurance frequencies for coverage or patient's requested treatment desires. Ultimately, after discussion, treatment may be required to continue care.

PATIENTS WITH INSURANCE COVERAGE:

- As a courtesy to you, we will be glad to help you process all your dental insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. We will be happy to request a pre-treatment estimate of benefits from your insurance carrier prior to completing any dental treatment, if you request us to do so. Routine treatment is generally performed without submitting a request for a pre-treatment estimate of benefits. You are, however, responsible for resolving any problems with your insurer and are ultimately responsible for full payment of the account.
- We would like to highlight a misconception that dental insurance was designed to pay 100% of dental care. That is not true. Dental insurance is a benefit to help offset the cost of dental care and seldom pays 100%. Most contracts have annual limits and/or various degrees of copayment. Insurance companies determine their fees based on the premium that you or your employer pays for your policy.
- Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality of dental care. The treatment recommended by our office is never based on what your insurance company will pay. Your treatment will never be governed by the insurance contract; it will be based off you or your child's needs.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company at the time we provide that service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- Should you elect to assign your benefits directly to our office, we allow 60 days from the date of service for the receipt of payment from your insurance company. If there should be a delay in the insurance company's processing, the entire balance is due at that time. Please remember that ultimately you are responsible for all services rendered. Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Sometimes there is a co-payment required from you as per your insurance agreement. Even if you have double coverage (if you and your spouse both have insurance), there may still be a portion that will be your financial responsibility.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors Accompanied by the Parent/Legal Guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.
Unaccompanied Minors: Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or treatment may be denied. The parent or legal guardian is responsible for full payment at time of service.

ADDITIONAL TERMS:
Appointments cancelled or broken without 24 hours' notice will result in a $25 broken appointment fee. By giving 24 hours' notice, this will allow other patients an opportunity to schedule their children and prevent us from scheduling your cancelled appointment too far in the future.
Checks returned by your bank are subject to a $35.00 processing charge. If your account is referred for collection, you will be responsible for any additional costs associated with the collection process.

Consent:
I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENDANTS IS MINE, DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED.

_____
Patient/Parent Name Printed

_____/_____
Patient/Parent Signature Date

Pediatric Dentistry of Mullica Hill, LLC
Marc Albano DDS