Paoli Family Dentistry Financial Agreement

We, the staff of Paoli Family Dentistry, thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship, and our goal is to not only inform you of the provisional aspects of that financial policy, but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact our Office Manager at 610-647-0353. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance or have an insurance that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our staff.

We make payment options as convenient as possible by accepting cash, checks, credit cards, and Care Credit. A $25 service fee will be charged for all returned checks.

_____ Initials

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving timely and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization, and referral information and to notify our office of any information changes when they occur. A pre-authorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participatory or non-participatory with their insurance plan. It is also the patient's responsibility to know whether there are waiting periods and/or policy limitations. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to reduce their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and we will assist in the filing of an appeal if these limitations are imposed. However, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier we cannot negotiate reduced fees with your carrier.

_____ Initials

Cancellation Policy

We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance; a missed appointment fee will be assessed based on the amount of time set aside for your appointment. These fees are typically $35, but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

Medical Records Fees

Patients are entitled under federal law to have access to their protected health information. We will follow all rules, guidelines, and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for copying the requested records.

As a courtesy, we will complete dental forms required for schools, sports, or extra-curricular activities at no charge.

Insurance consent/assignment

I agree to assign insurance benefits to Paoli Family Dentistry, whenever applicable. I understand that I am ultimately responsible for all charges whether paid by my insurance or not. I understand it is impossible for the staff of Paoli Family Dentistry to know the policy coverages, limitations and exclusions for every dental plan, as they are constantly changing. I authorize Paoli Family Dentistry to release information required to secure benefits. I understand that I am responsible for my insurance co-payment at the time services are rendered. I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf and I will personally be active in the resolution of claims delay or unjustified reductions or denials.

_____ Initials

I have read and understand the above financial policy. I accept the responsibility that the payment of dental services are mine, due and payable at the time services are rendered unless financial arrangements have been made.

In the event of default: I (we), the undersigned, accept the fee charged as a legal and lawful debt and agree to pay the said fee, including any/all collection fees (33.3%), attorney fees and/or court costs in order to collect on the debt. You agree, in order for us to service your account or to collect fees you owe, Paoli Family Dentistry and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that Paoli Family Dentistry, its employees and/or agents may contact me/us as described above.

Patient Name:_____

Signature of Patient: _____

Signature of Insured and/or Responsible Party:_____

Date:_____