OFFICE FINANCIAL POLICY

Terms and Conditions
Please Read and Sign Below

Our office is committed to providing you with the best possible professional service. In order to help us achieve our goals, it is essential that you assist us in controlling healthcare expenses by understanding our financial policy and you dental plan benefits.

FOR PATIENTS WITH PPO DENTAL INSURANCE: We require your percentage of total charges to be paid the day of treatment. As a courtesy to you, we will submit **without additional charge** your bill to your insurance company usually within a 24 hour period of time from the date of service. We must have completed and signed Insurance Form with "Assignment of Benefits: paid directly to this office. The Insurance Company is sent a follow-up notice at 30 days, but we shall not wait any longer than 60 days from the date of service for payment from your insurance company. At the end of this 60-day period, if payment has not been received from your Insurance provider, you are expected to pay the total unpaid portion of your account immediately. Please remember, you have the contract with your insurance carrier, not us. **You are responsible for knowing your benefits, deductibles and exclusions of your policy.** Upon payment from your insurance company, any unpaid portion of your account will be due in full immediately. You will receive an updated statement from our office reflecting your balance.

FOR PATIENTS WITH HMO DENTAL INSURANCE: We require of your co-pays at time services are rendered. You are on a discounted fee schedule, which makes you eligible for dental treatment at a greatly reduced rate. **WE DO NOT BILL YOUR INSURANCE AT ALL FOR ANY PORTION OF YOUR DENTAL TREATMENT.** All payments made for your dental treatment will reflect your discounted insurance rates, plus possibly, your out-of-pocket costs for non-covered dentally necessary treatment.

FOR PATIENTS WITH DENTI-CAL INSURANCE: As a member with Denti-Cal benefits, an office visit fee of $1.00 will be expected at each visit. With this benefit program Denti-Cal will pay for services rendered according to the list of surcharges set by Denti-Cal. Some program members with a **SHARE OF COST** obligation can be applied to an individual or family as a whole, which can affect payment paid by Denti-Cal. In these cases the Denti-Cal member is responsible for payment to the office for services rendered.

As a courtesy to you, our patient, upon completion of the examination, if a root canal is needed, we will submit an authorization to Denti-Cal, please allow 4-6 weeks.

I understand that the dental estimate given to me, by this office for my dental treatment will only be valid for a (6) month period of time. A service charge of 1.1/2% per month (18% per annum) or whatever the current rate permissible under state law is at that time, may be charged on the unpaid principal balance on all accounts not paid within 60 days of the treatment date. There is a $35.00 returned check fee and $20.00 collection fee. I have read the above conditions of financial responsibility and understand this office policy. **The patient is ultimately financially responsible for their account balance.** If you have any questions you can inquire with the front desk regarding these matters.

Signed: _____ Date: _____

[OVER]

ASSIGNMENT OF BENEFITS

I understand that I am personally responsible for the cost of my dental care. I agree to pay for any dental work rendered by this office if for any reason whatsoever my insurance carrier denies liability, and I will notify this office of any change in eligibility for insurance coverage. If default of the above agreement on my part necessitates legal action I shall assume all responsibility for interest, and reasonable attorney fees.

Signature: _____ Date: _____

Witness: _____ Date: _____

ASSIGNMENT OF BENEFITS

I hereby authorize the _____ insurance company to make payment directly to Robert A Camhi Dental Inc for the dental benefits otherwise payable to me. The foregoing agreement is made in consideration of professional services beginning on _____. I hereby represent that I am of legal age and legally competent to make this assignment.

Signature: _____ Date: _____

Witness: _____ Date: _____