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Financial Policy

This form is our documented effort to inform you of our policy regarding processing dental claims to your insurance provider, including payment options for any out-of-pocket portions not covered. **WE** make every effort to inform you of your treatment needs, fees, estimated insurance coverages and financing options.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. Shrewsbury Family Dentistry will make an effort to anticipate any changes in the treatment plan and advise you at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

Our office will make every effort to accommodate your scheduling needs.

Your insurance company does not participate with our dental practice. Any out-of-network balances **NOT COVERED** by your dental reimbursement plan is due at the time of your treatment, unless financing arrangements have been made. We offer 10% off for our **patients 65 and over** with cash, check or debit card using a PIN number. Insurance estimates are based on the information provided by you and/or your dental plans. We are happy to submit your insurance claims as a courtesy to you but it is your responsibility to contact your insurance company to determine which services are covered under your plan.

We are required by law to inform you of the following:

- Any and all unpaid balances 90 days and over are subject to a $5.00 billing fee per monthly billing period. There is a $30.00 returned check fee assessed to all accounts when a bank returns a check to us for insufficient funds.
- We reserve the right to charge $50.00- $100.00 for **TWO** consecutive broken appointments.
- An itemized statement listing your services will be mailed to you when the Explanation Of Benefits (EOB) is received from your insurance plan. Any outstanding balances are due within 15 days of the statement date.
- Not all services may be covered by your insurance plan. It is your responsibility to know what your insurance company provides.
- Delinquent balances left unpaid over 90 days without payment or communication from you may be sent to District Court or a professional collections agency.
- Our office charges a $15.00 PPE Fee per person, per visit, as advocated by the American Dental Association in order to provide additional precautionary measures during the Covid-19 Pandemic.

PLEASE INITIAL ALL OF THE FOLLOWING PAYMENT OPTIONS IN ACKNOWLEDGEMENT.

I have dental insurance through

[ ] ____

[ ] Deductibles and out-of-pocket portions are due at the time of service. For treatment requiring lab services, (ie; crowns/bridges, implants, appliances, dentures, partials etc.) all out-of-pocket balances **MUST** be paid prior to the insert date.

[ ] Insurance checks that are sent directly to the patient **may** be signed over to our practice but MUST be accompanied by the Explanation of Benefits (EOB).

☐ Payment by cash or check at the time of service. (Ask about our Senior Citizen Discount of 10% for age 65 and over with check, cash or debit card with pin number.)

☐ Payment by check at the time of service for any out-of-pocket amount not covered by your dental carrier.

☐ Payment by credit card at the time of treatment. (We accept MasterCard, Visa, Discover) For larger treatment cases over $500.00, we offer 5% for credit cards payments, 10% for check/cash if balance is paid in full.

☐ Automatic monthly billing to your MasterCard, Visa or Discover. Any scheduled payments that are asked to be credited/returned are subject to a $25.00 re-processing fee. Any scheduled payments that are cancelled less than 72 hours prior to approved processing date will be charged an additional fee $20.00.

☐ Care Credit Financing available. Care Credit has their own terms for financing that can be located on their website at carecredit.com *Promotional 0% interest rates for 6 months to a full year!

☐ Lending Club for amounts $500.00 and over at lendingclub.com *Promotional rates may vary.

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS PRIOR PAYMENT ARRANGEMENTS HAVE BEEN APPROVED.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to Shrewsbury Family Dentistry of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and/or lab fees. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

As validated by my signature on the bottom of this form, I understand and agree to the Financial Policy for Shrewsbury Family Dentistry.

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Signature of Patient or Guardian Date

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Printed Name