

LINDEN DENTAL ASSOCIATES - FINANCIAL POLICY

Thank you for choosing **Linden Dental Associates** for you and/or your family's dental need. We are committed to providing you with the highest quality dental care. Your trust is very important to us so our goal is to make sure you fully understand your treatment needs and financial responsibility before treatment begins. We will make every effort to work with you to ensure that your dental needs be met.

PAYMENTS:

Payment is due at the time service is provided. Our office accepts cash, checks, MasterCard, Visa, Discover, American Express and CareCredit.

Patients with insurance: co-pays, deductibles, and/or portion not covered by insurance are due at the time of treatment.

Patients without insurance: all payments for dental services rendered are due at the time of service.

PATIENTS WITH DENTAL INSURANCE:

Our friendly staff will be happy to help you maximize your dental benefits. We can help you verify your dental insurance coverage and benefits. Therefore, please make every effort to ensure that the information we have on file is accurate. That way, we'll be able to give you a closer estimate of your portion of the fee for each visit. Most plans only cover part of your dental service which means that you are responsible for any part that's not cover and/or any deductible. Many dental insurance policies have exclusions and limitations that can affect your out-of-pocket cost.

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a **COURTESY** to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

All charges you incur are ultimately your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. 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 90 days, we will ask that you contact them 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.

MISSED APPOINTMENTS:

We, here at Linden Dental Associates, are truly blessed with wonderful patients. We fully understand that life can be unpredictable and many times things come up unexpectedly. However, please understand that your appointment time is reserved especially for you. When life does take an unexpected turn and you cannot make it to your appointment, we respectfully request that you notify us at least **24** hours ahead. A charge may be assessed for multiple missed, short notice or cancelled appointments.

ACKNOWLEDGEMENT & 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 the dental office. I understand that responsibility for payment for of dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Patient/Parent name printed _____

Patient/Parent signature _____

Date _____