Financial Policy

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship.

Insurance:

We will prepare all of the necessary forms for this important benefit. However, we remind you that your policy is an agreement between you and your insurance company, even if we participate with your particular insurance. If we are participating with your insurance, we have agreed to use their fee schedule and will give you an estimate of what your patient portion will be, however; we can make no guarantee of what they will pay. For a more accurate estimate, we can send a pre-treatment estimate to your insurance company and will generally receive a detailed response within 4-6 weeks. We will do everything in our power to see that you receive your maximum benefits. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. We will send a statement for any remaining balance, which is payable within 30 days.

Payment arrangements:

Patient portion will be expected at the time of the appointment. If we participate with your insurance company, they will send us the insurance check, so only the patient portion would be expected at that time. If we do not participate with your insurance company, the full amount would be expected at the appointment, since insurance will send the check directly to the insured.

We realize that financial problems may affect timely payment of your account. Please contact us promptly to discuss payment arrangements.

Missed appointments/Late cancellations:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for missed appointments. Cancellations are requested 24 hours prior to appointment. A **$25.00** fee will be charged for a second missed appointment. After a third missed appointment, you will be discharged from the practice.

Assignment and release:

I hereby authorize my insurance benefits be paid directly to the dentist. I understand that I am financially responsible for non-covered services. I also authorize the dentist to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY MOUNT JOY DENTAL ASSOCIATES. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION, IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

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Print Name Signature of person responsible for account

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Date