

FINANCIAL POLICY

We feel that all patients deserve from us the very dental care we can provide. Further, we feel that everyone benefits when definite financial arrangements are agreed upon.

INSURANCE

While the filing of commercial insurance is a courtesy that we extend to our patients, all charges for services and materials are your responsibility from the date services are rendered, unless our office has a contractual agreement with your dental plan prohibiting a portion of the charges. In this instance you will be responsible for all charges up to the contracted fee. A 45-day grace period will be allowed for insurance payment, provided co-payments are made at time of service. Prepayment of services may be required for extensive treatments plans.

Commercial insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. Our fees reflect our services, not an insurance company's reimbursement schedule. Certain insurance companies may choose not to pay your dental fee in full. This is not uncommon and is unfortunate for those affected by this problem.

If your insurance company selects a level of reimbursement (an arbitrary value sometimes referred to as "usual and customary") which is below our standard fees, the responsibility of the remaining balance is placed on you when applicable. The payment schedule will be based upon the estimated benefit coverage provided by your insurance company.

PREDETERMINATION OF INSURANCE BENEFIT

A predetermination of benefits is a written request for verification of benefits. Although insurance will not guarantee payment until a claim is received and processed, a predetermination gives an estimate of how much of a proposed treatment plan will be covered under your dental program. A [predetermination](#) lets you figure your costs before you receive major treatment. We will be happy to file a predetermination of insurance benefit on your behalf for major or unusual services. There is an administrative charge of \$25.00 to file the predetermination. This fee will be applied toward balance once treatment has been initiated.

MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians of the minor) is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless prepayment has been made for services to be rendered.

NSF CHECKS

All checks returned for non-sufficient funds will incur a \$27.50 service fee.

DELINQUENT ACCOUNTS

Should the account become delinquent (past 45 days), the patient (parent/guardian if patient is a minor), will be responsible for all collection costs, which can be an additional 50%, including agency fees, attorney fees, court fees, or any other fees incurred to collect this debt.

MISSED APPOINTMENTS

Unless canceled, at least 24 hours (72 hours for Monday appointments) our policy is to charge for missed appointments at the rate of \$25.00 per one-half hour scheduled. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION AND RELEASE

I authorize the Dentist to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such dental care to third party payers and/or other health care practitioners. I authorize and request my insurance company to pay directly to Berman Endodontics, LLC , insurance benefits otherwise payable to me.

I have read and agree to the above financial policy.

X _____
Signature of patient (Parent/Guardian if minor)

X _____
Date