

Financial Agreement

Main Street Family Dentistry, P.C.
712 W. Main Street, Suite 100
Plainfield, IN 46168

Whether you are a new patient to our practice or we have had the pleasure of serving you over the years, we would like you to be aware of our financial policies. We are committed to your treatment being a success. Please understand that your bill is part of your treatment.

If you do not have insurance, we do expect payment at the time of service. If you prefer, we can assist you in receiving financing through an outside financial institution. Please let us know if you would like to use this option.

Treatment of Minors: If both parents have insurance, the insurance of the parent whose birthday falls first in the calendar year will be considered primary for the child, and the other parent's insurance will be secondary. When the parents are divorced, we will consider the parent/legal guardian who presents a child for care to be the responsible party for payment of services, regardless of financial responsibility established in a divorce decree. Further, care for a patient under 18 years of age must be authorized by a parent, legal guardian, or someone to whom you give written authorization to present the child for care.

Insurance Patients: If you have dental insurance, we will file insurance claims on your behalf. We do this as a courtesy to our patients and are anxious to help you receive your maximum allowable benefits from your insurer. Even though we still file insurance claims for you, we need your active participation in the insurance claims process. Remember that your insurance contract is between you and your insurer. We are not a party to this contract. If your insurance company pays only part of your bill or rejects your claim, you are financially responsible for the balance and are to pay it upon receipt of your statement. If your plan has a deductible, payment is expected at time of services. It is also our policy that all co-insurance (the amount owed after insurance pays its portion), be paid at the time of service. This is an estimated amount. Insurance companies determine payment when the claim is received. If your insurance company has not paid the full balance within 60 days, the balance of your account will be transferred to you. You are responsible for the timely payment of your account. In the event that your payments are not received in a timely manner, you will be responsible for the cost of collection.

Secondary Insurance: We will be happy to file secondary insurance free of charge for you. If you do have a secondary insurance carrier, you need to let us know the carrier's information before the primary claim is filed.

Additional Costs: Some dental procedures may require an extra cost from a dental or medical lab, which your insurance company may not assist with payment. We will notify you, whenever possible, at time of treatment.

X-Rays: If you have current x-rays from a previous dentist, it is your responsibility to bring those to your appointment. If you do not notify us that you have current films/digital X-rays, we will take new ones. Insurance companies have limitations on how often they will pay for x-rays. Therefore, it is important that you let us know if you have had recent ones taken.

UCR (Usual & Customary Rates): Our office is committed to providing our services with fair and honest process and we charge what is usual and customary for our area. We review our charges annually to make sure they are within these limits. You are responsible for payment in full regardless of any insurance company's determination of usual and customary rates.

Patient Responsibility Balances: You will be responsible for: Services not covered by insurance; Co-pays and balances remaining after your insurance company has paid, including deductibles and co-insurance (percentage that is your obligation) due on day of services. Payment in full is expected within 30 days from your first statement advising you of the balance due. For your convenience, this office accepts cash, Visa, MasterCard, debit card and checks as forms of

payment. If a check is returned to us for any reason there will be a \$28 charge. **A monthly billing charge of \$5 will be assessed on all accounts over 60 days old.**

Missed Appointments: Your good dental health is our main objective. Therefore, it is extremely important for you to keep all of your scheduled appointments. We understand that emergency situations do arise that may require you to change an appointment. As a courtesy to other patients and our office, we ask for as much advance notice as possible. If any appointment is failed, or repeatedly changed, **a fee will be charged or you may be asked to find a new dentist.**

Acknowledgement and Authorization: I have read, understand, and agree to the above policies listed on page 1 and page 2. Regardless of any insurance I may have, I am ultimately responsible for payment of any professional services rendered. I authorize the release of medical information necessary to process a claim for benefits under my policy and assign payment of my insurance benefits to Main Street Family Dentistry, P.C. If my account should become delinquent, I agree to pay the costs of collection, including agency fees, attorney fees, and court costs.

_____ Date _____ 20 ____

Signature of Patient or Parent if Minor (or legal Guardian)