

Financial Menu

Thank you for choosing Cary Family Dental by Dr. Niraj Patel (hereinafter referred to as "we" or "Practice") for your dental care. Our goal is to provide for you a pleasant and relaxing environment with the finest care possible. We will strive to educate you about your diagnosis and treatment alternatives as well as your financial options. This document is designed to help you understand our office procedures and financial policies.

Payment

Payment is expected the day dental services are provided. For your convenience Master Card, Visa, Discover, American Express, debit cards, checks, and cash are accepted. We will provide a written Treatment Proposal that will detail your diagnosis, treatment alternatives, estimated insurance coverage (if applicable), and your estimated portion due to begin treatment. No procedure performed on the human body can be guaranteed, as such payment is due and fees non-refundable regardless of treatment outcome. Payment for services rendered is also required if you decide to abandon a course of treatment in favor of an alternative form of treatment.

Dental Insurance

As a courtesy to you we accept, and will file, most primary insurance plans that do not require a specific provider. Please provide us with your identification card. Dental insurance is not intended to be a "pay all" service but is intended to help reduce your "out of pocket" expenses. Please be prepared to pay your deductible and estimated co-payment in full as treatment is initiated. We do NOT accept assignment of benefits for secondary insurance. Therefore any balance remaining after your primary insurance has responded is due in full. As a courtesy of those with secondary insurances, we will prepare a claim form and submit it on your behalf when you have paid your account in full.

Insurance Payment

As a courtesy to you, we will file your primary insurance claim and are willing to wait up to 45 days from the date of service for payment. If payment has not been made, we will contact your carrier and strive to resolve any reason for delay. If unable to immediately resolve the situation a statement will be sent to you for immediate payment by the responsible party. Thereafter we will gladly assist you in attempting to obtain direct reimbursement from your carrier. WE MUST EMPHASIZE that our relationship is with you and not your carrier. Our primary concern is for your well-being and we structure our care accordingly. Insurance companies determine benefit packages and payment rates ("usual and customary" or UCR) by the plan type that is purchased by the employer/insured party-not by the level of care provided by our office. All charges including interest, accrued from the date services are rendered, are your responsibility regardless of insurance benefits, arbitrary determination of UCR payment, or lack thereof.

Appointments

We value your busy schedule and strive to see patients at their appointed time; we ask you to extend the same courtesy. Whenever possible please provide a minimum of 48 hours advance notice when requesting a scheduling change so that we can arrange care for other patients experiencing urgent dental needs. Failure to give adequate notice will result in a minimum office fee of: \$45 and up to \$100 charged to your account that must be paid prior to rescheduling.

Returned Check Fee

A fee of \$25 will be charged for any returned check. The entire outstanding balance and returned check fee must be paid immediately upon notification from our practice.

Acknowledgement, Release, and Authority

I as the patient, or as the authorized guardian or responsible party for the patient named, consent to treatment as necessary or desirable, including but not limited to drugs, medicines, performance of clinical treatment, labs, imaging, or other studies that may be performed, ordered or used by Practice. I certify that I am here only for the medical and/or dental treatment requested and also certify that I am not representing any third party or other entity. I also certify that I am not on Medicaid, and also understand dental services are not covered by Medicare.

I authorize Practice to use or release any protected health information, as used in Health Insurance Portability and Accountability Act (HIPAA) and in the manner described in Notice of Privacy Practices, to third party payers or other health practitioners as reasonably necessary for my treatment proper or for reimbursement thereof, and further hold harmless Practice from any and all damages resulting from the reasonable use thereof. I also give my consent to be contacted regarding my dental health, treatment, and scheduling and account information by telephone, e-mail, postcard, newsletter, and /or letter.

I authorize and request my insurance company to pay the Practice any monies due me as reimbursement for services rendered by Practice. I understand my insurance carrier may pay less than the total fee for services rendered and unconditionally agree to be responsible for and pay all charges incurred on my behalf or on behalf of those for which I am responsible. I permit a copy of this authorization to be used in place of the original.

I agree to pay treble damages if I cash any insurance or other check that represent reimbursement to Practice for services rendered and I fail to immediately tender the monies due to Practice. **I agree and understand** in the event I do not pay Practice the balance due and my account is placed in the hands of a collection agency and/or attorney for collection proceedings, I will be legally responsible for all costs of collection, including but not limited to: collection agency fees, including those derived as a percentage of outstanding balance, court costs, litigation expenses, attorney's fees, as well as other incidental expenses incurred by Practice, and further I consent to the jurisdiction of the Small Claims Court or Superior Court of McHenry County, IL and agree that Illinois law governs all matters arising out of this agreement.

I further understand a 1.5% finance charge per month (18 percent annually) will be added to my account for any balance over 60 days, regardless of any pending insurance claims. I agree to pay Practice a minimum fee of \$45 and can range up to \$100 for any appointment I schedule and fail to arrive for or cancel with less than 48 hours notice. I certify that any information I have provided today is correct to the best of my knowledge. I also understand that it is my responsibility to inform Practice or any Responsible Party and, if the patient is a minor, I certify I am legal guardian.

Patient Name: _____ Responsible Party: _____

Signed: _____ Date: _____