



FINANCIAL POLICY

Patient Name: _____ Date: _____

Welcome to Schneider Family Dentistry! We are pleased that you have chosen us as your dental health care provider. We strive to provide the highest level of dental health care with the highest degree of patient satisfaction. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care.

PATIENT RESPONSIBILITY

FEE FOR SERVICE: Schneider Family Dentistry is a fee-for-service provider. Patients or their legal representative (parent or guardian) are ultimately responsible for all charges for services provided. All services for patients who are minors will be billed to the custodial parent or legal guardian.

We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. If you do not have insurance, you will be asked to pay the full amount of the charges for the visit. If you have insurance, you will be asked to pay a portion of the charges for the visit, plus any amount remaining after insurance has been applied.

OUTSTANDING BALANCES: After your visit, you will be billed for any outstanding balances. We usually send out statements every month, beginning when the balance becomes the patient's responsibility. All outstanding balances are due upon receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your balances can also be paid through your patient portal.

If you have an outstanding balance for more than ninety (90) days, you may be referred to a collection agency and charged a collection fee in addition to the balance owed. In addition, if you have an unpaid delinquent amount, we may not allow you to schedule any additional services until payment arrangements have been made, or we may discharge you as a patient.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a driver's license or photo ID) at every visit. If you do not provide current proof of insurance, you may be billed for the full amount due. If you provide your insurance card at a later time, we may be able to retroactively bill the services to the insurer, depending on the insurance plan's requirements.

IN NETWORK: We are 'in network' with Delta Dental and United Concordia. We require a co-payment or co-insurance payment at the time of your visit. You are expected to pay the entire amount determined by your

insurance to be the patient responsibility, and we will bill you for any amount remaining after the co-payment or co-insurance. Most insurance plans require you to pay a predetermined amount (the 'deductible') before insurance will cover certain charges.

OUT OF NETWORK: For all other insurance providers, we are an out-of-network provider. If we do not participate with your insurance plan, you will be required to pay for your visit at the time of service, and we will submit a courtesy claim to your insurance provider so they can reimburse you directly. If the total charge amount is not available at the time of check out, you may be required to pay a deposit as described above.

PATIENT RESPONSIBILITY: Some insurance plans tell us exactly what you will owe at the time of your visit; in that case, we may request full payment for your share when you check in or out. Other insurance plans do not provide immediate information regarding patient responsibility. In that case, you will be asked to pay a deposit when you check in or out. When you make a deposit, you will pay an estimate of the expected patient responsibility; when your insurance company notifies us of your patient responsibility, we will either send you a statement for the balance due or issue a refund.

NON-COVERED SERVICES: It is your responsibility to contact your insurance company to determine whether a particular service is covered. If we provide you a non-covered service, you are expected to pay for these services at the time of your visit. Our billing staff will assist you in attempting to resolve any appeals.

UNINSURED PATIENTS

If you do not have insurance or if the services provided are not covered by your insurance, payment for all services is due at the time of your visit. A discount is available if you pay in full by cash or check at checkout. If you do not pay the total charge amount at the time of checkout, you will be required to pay a deposit that will be applied to your account, and you will be billed for the remaining amount. If you have a large balance, a payment plan may be set up for your convenience.

LATE ARRIVALS, CANCELLATIONS & NO-SHOWS

LATE ARRIVALS: If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or wait for an open appointment time on that day's schedule

CANCELLATIONS: If you are unable to keep a scheduled appointment, please call at least one (1) business day in advance or we may consider you a 'no-show'.

NO-SHOWS: If you miss your appointment, you may be charged a \$50 fee for a missed appointment. This fee will need to be paid before you can schedule another appointment, and may not be billed to insurance. If permitted by state law, you may be discharged as a patient following three (3) no-shows in a one-year period (365 days).

My signature acknowledges my understanding of and agreement to the practice financial policy. A parent or guardian must sign for patients under the age of 18.

Signature: _____
(For patients under the age of 18, a parent or guardian must sign)