Rand Dental Associates, P.A.
Financial Policy

This financial agreement is intended to facilitate our ability to provide excellent service while informing you of your financial obligation to our practice.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that, as your dental care provider, our relationship is with you, **not with your insurance company.** Your insurance policy is a contract between you, your insurance company, and/or your employer. Our office is not party to that contract. **If payment from your insurance company is not received within 90 days from date of service, you will be expected to pay the balance in full.** If you **DO NOT** have insurance, payment is due in full at the time treatment is provided.

PAYMENT:

Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express. Outside financing is available through CareCredit upon request and approval. Returned checks and balances older than 30 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually.) If at any point there is a credit on your account, you may apply the credit towards future dental work, or a refund check will be issued to you upon request. Additionally, our office will charge you $100 for any appointment that you do not keep without having given 24-hour notice of cancellation. The returned check fee is $50.

IF YOU HAVE INSURANCE:

As a courtesy to you, we will help you process all of your insurance claims. **Your estimated co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments.**

INSURED PATIENTS – PLEASE READ CAREFULLY:

The amount of coverage paid by your insurance company may be based on your insurance company's own reduced fee schedule for treatment and may be less than actual charges, resulting in lower coverage to you. We have no control over this situation and cannot be held responsible if an estimated co-payment is less than what the insurance company actually pays on the claim. Lower payment is a direct result of the plan selected by **you or your employer**. Some insurance plans have allowances for specialist fees. In the event a procedure is performed by a specialist in this office, you are responsible for the fee allowed by your insurance company. In some instances, it may be higher than the standard office fee. Furthermore, any estimate of coverage provided to us by *your* insurance company represents an estimate only and *never* constitutes a guarantee of payment. As such, we too can never guarantee payment on a claim. In no way is Rand Dental Associates, P.A. to be held liable for any non-payment of claims by your insurance company. You, as the insured, bear the ultimate financial responsibility in covering the financial cost of all treatment rendered. Please be advised that **WE CANNOT WAIVE ANY CO-PAYMENTS.** We are required **BY LAW TO COLLECT CO-PAYMENT.**

ALTERNATE BENEFIT CLAUSE:

This is a clause established by insurance companies that outlines their right to decrease the amount they will pay for certain services if there is a less expensive alternative service. This clause is most often applied when molar teeth are restored with white fillings or porcelain crowns. For example, if you had a cavity filled with a white filling then your insurance may only pay the benefit for a silver filling. Any difference in cost is the patient's responsibility. As a result of our commitment to providing you with the best aesthetic result, **Rand Dental Associates, P.A. only offers white fillings and does not have amalgam in the office.**

REPRODUCTION OF RECORDS:

The American Dental Association (ADA) mandates certain rules with respect to the fees involved in reproduction of records. In accordance with the ADA's rules, we will reproduce a patient's records upon request by the patient or other authorized representative for a minimum fee of $10.00. If the records requested exceed ten (10) pages then we will instead charge $1.00 per page, or $100 for the entire record; whichever is less.

I certify that I have read, understood, and agree to this financial policy, and that it applies to myself and any dependents.

Signature: _____ **Date:** _____

Please check one:

- ❑ **I waive my right to a copy of this agreement.**
- ❑ **Please provide me with a copy of this agreement.**

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