# FINANCIAL POLICY AND RESPONSIBILITY AGREEMENT

## Effective 1-1-2016

Thank you for choosing Monokian Family & Cosmetic Dentistry as your dental care provider. We are committed to redefining the dental experience by providing you with a caring and compassionate team, the highest quality care and state of the art technology for diagnosing and treating your dental care needs, all in a safe and comfortable environment.

We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of that financial policy but to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact any of our team members at 856-983-9620.

We believe this level of communication and cooperation will allow us to continue to provide quality services to all of our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service unless a payment arrangement has been approved in advance by our team.

**OUR FINANCIAL POLICY IS AS FOLLOWS:**

1. Payment is due at the time of service.
2. Affordable low monthly payment plans are available through Care Credit® and Wells Fargo Health Advantage®
3. We accept cash, personal checks and most major credit cards including Visa, MasterCard, Discover and American Express.
4. If your out-of-pocket cost for any treatment is expected to exceed $1,000, a deposit will be required. Should you need to cancel your appointment, this deposit will be refunded if you cancel with the required 48 hours' notice before your scheduled appointment time. In the event of a late cancellation or no-show, our deposit, minus the cancellation fee, will be refunded to you.
5. **Estimated** co-payments are due at the time of service.
6. **All quotes are estimates only. Our office cannot guarantee**

**FOR PATIENTS WITH DENTAL INSURANCE**

We are a participating provider with Delta Dental Premier, United Concordia Elite PPO, Horizon Traditional and we are a non-contracted provider with the Guardian Preferred plus network. **We are not a participating provider with any other PPO or HMO/DMO programs.** Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefits under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out of network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out of network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

**LATE CANCELLATIONS / MISSED APPOINTMENTS**

Your appointment reserves time for treatment with the doctors, hygienists, and assistants. Missing an appointment prevents others from receiving timely dental care. If you need to reschedule an appointment, be sure to notify us at least 48 hours in advance. **Missed appointments, and appointments cancelled less than 48 hours in advance, are subject to a $75 per hour fee.** If your appointment required a deposit, any late fees will be deducted from it.

**PAST DUE BALANCES AND COLLECTION ACCOUNTS**

We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in management of your account. Our goal is to provide quality care and service.

Any balance more than 60-days past due will require payment in full prior to scheduling any additional appointments and maybe subject to a $5.00 per month late penalty fee. In the event that your account is placed in a collection status, we reserve the right to dismiss you from the practice, with 30-days written notice. We also reserve the right to reverse any discount or courtesy that was applied to services that have resulted in the outstanding balance. Collection accounts may be subject to legal expenses and interest.

**I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY AND RESPONSIBILITY AGREEMENTAND AGREE TO COMPLY WITH ALL OF THE TERMS AND CONDITIONS, AND I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THIS ACCOUNT.**

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**Print Patient name** **Signature of Patient/Parent or Guardian**

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**Date**