

ASHBY PARK PEDIATRIC DENTISTRY
FINANCIAL POLICY

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our front office staff is trained to inform you of the financial policies of this office. Your signature below indicates that you understand and accept our policy. **Payment is due at the time of services.** We accept all major credit cards, cash, or checks. We consider the account responsible party the person who signs the financial policy.

Dental Insurance

Your insurance is a contract between you, your employer and the insurance company. We are **NOT** a party to this contract. We will bill your primary insurance only as a courtesy to you. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in lower payment from the insurance company. You will need to supply our office with a copy of your dental insurance ID card. **After 45 days from the date of service PAYMENT IS EXPECTED IN FULL FROM YOU.**

Sedations

A reservation fee of \$100.00 is required to make a sedation visit appointment. This fee will be applied to your portion of the bill that day. If the appointment is missed or if the patient is excessively late, the \$100.00 fee will be kept as a missed sedation fee charge.

Medicaid

Our office accepts South Carolina Medicaid **ONLY**. We will bill Medicaid for the covered services, but you are responsible for any charges not covered at the time of service. If the recipient is not eligible at the time of service you will be responsible for all charges incurred. You will need to supply our front office with a copy of your Medicaid card. **** ALL SERVICES ARE NOT COVERED BY MEDICAID**** If a sedation appointment is missed or if the patient is excessively late, you will be asked to transfer their records to another doctor.

Self pay (NO INSURANCE COVERAGE)

All fees must be paid at the time of service. We offer a 5% discount if you pay by cash/check at the time of service and a 3% discount if you pay by credit/debit card.

Missed Appointments

In order to allow the best possible care our patients, we reserve a specific time just for you and make every effort to see you as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your appointment a 24- hour notice is required or a \$25.00-\$45.00 charge will apply. That fee would have to be paid to schedule a new appointment. Patients with two missed appointments will be asked to transfer their records to another doctor.

A **finance charge** will be imposed on each item of your account, which has not been paid within thirty (30) days from the time the item was posted to your account. This finance charge will be computed at the rate of 1 ½ percent per month. The minimum finance charge is \$.50.

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all the collection costs that are incurred. If we have to refer collection of the balance to a lawyer, you agree to all lawyers' fees, which we incur, plus all court cost.

You will need to request in writing and pay reasonable copying fee (currently \$25.00) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. After such request we have up to fifteen (15) days to send your records.

Signature

Date

Should the account fall past due greater than 60 days, I authorized that the unpaid balance be charged to my major credit as listed below:

Card Type

Card Number

Exp. Date

Name as it appears on card

Signature

Date

Name of Patient

ASHBY PARK PEDIATRIC DENTISTRY

Dr. Jennifer G. Fogle

Dr. Sairah Awan

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations, I hereby acknowledge that I have read and understand this practice's "NOTICE OF PRIVACY PRACTICES."

The following people listed below may have access to the patients records:

Person who may have information

Relationship to Patient

Person who may have information

Relationship to Patient

Person who may have information

Relationship to Patient

Ashby Park has my permission to contact me in the following ways:

Phone Call (confirmation)

Leave Message on Machine

Mail (recall card)

Email

PLEASE PRINT

Patient(s) Name:

DOB

DOB

DOB

Who has custody of the patients listed above:

Signature of Parent/Legal Guardian

DATE

Please PRINT name Listed Above

Relationship to Patient(s)