Beaufort Family Dentistry

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Beaufort, SC 29902
843-524-6363
www.Beaufortfamilydentistry.com

FINANCIAL POLICY

Please remember to keep our office informed of any changes in your insurance coverage or employment. If you have moved or changed your phone number, please make sure to update this information during your appointment. We remind you that the responsibility rests with the patient being treated or the parent/guardian to ensure full payment for treatment.

If You Do Not Have Insurance, we ask that you pay for your office visit at the time of your appointment.
If You Have Private Insurance, please give your insurance card and any necessary insurance forms to front desk staff during your appointment. As a convenience to you, we can complete the claim forms and submit them directly to your insurance company. You may be required to make a payment (co-payment, partial payment, deductible, etc) for your visit today by cash or credit card. Most insurance coverage involves deductibles and/or percentage allowances with the result that the entire bill is seldom covered in full by the insurance company. If your insurance company does not cover the full cost of treatment as charged, you will be sent a statement for the remaining balance. We recommend you become directly involved in communication with your insurance company in order to expedite payment. We know questions can arise on insurance matters and these can be discussed with our front desk staff. We will be happy to help you receive maximum benefits; however, the agreement of the insurance company to pay for dental care is a contract between you and the insurance company and we have no leverage to obtain payment from your insurance carrier.

If you have Medicaid Insurance, please give your insurance card to front desk staff during your appointment. If your insurance is inactive you will be responsible for the total cost of your appointment visit. You are responsible for knowing if your insurance is active on the appointment date. We will make you aware of any noncovered services prior to administering them. If you agree to receive any noncovered services, you will be responsible for paying them in full on your appointment date. If your plan has a copay or coinsurance, you will be responsible for paying them in full on your appointment date.

Please make sure we are aware if you have other insurance coverage in addition to your Medicaid insurance. We are required to file for payment with your non-Medicaid coverage prior to billing Medicaid. If Medicaid has incorrect information on file, it is your responsibility to update this information with them to ensure prompt payment of claims. If we are unable to collect payment on a claim due to Medicaid having the wrong information on file or record of primary insurance coverage through another plan that was not supplied to our office, we will be unable to schedule future appointments until this information has been updated with your Medicaid plan and/or our office.

Assignment of Benefits and Release of Information: I authorize payment directly to the dental office and the release of necessary information to my insurance company to determine liability for payment and to obtain reimbursement for any claims.

Fees Dental insurance policies restrict payment for some services, use restricted fee schedules (called Usual and Customary Rates) or contracted rates, and exclude some procedures based on prior conditions or length of time on the plan. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment. You will be responsible for any balance excluded. **Patient co-pays are due at the time services are rendered.**

CROWNS, BRIDGES, DENTURES, PARTIALS, AND OCCLUSAL GUARDS REQUIRE WORK FROM AN OUTSIDE LAB FOR COMPLETION OF TREATMENT. **IF YOU DO NOT RETURN FOR THE DELIVERY OF THIS TREATMENT THIS AMOUNT WILL NOT BE REFUNDED**. This is to cover the cost of the lab bill, supplies, and labor we incurred.

Delinquency: Your account is considered delinquent if there have been no payments in 90 days. If your account falls into delinquency, you agree to pay any and all collection agency charges, attorney fees and court fees. Accounts turned over to collections will incur a 25% collections fee added to the balance. **Please note: We require 24 hours' notice to cancel an appointment to avoid a $45 broken appointment fee**

I have received and read the Financial Terms and understand that I am responsible for any unpaid balances on the account. By signing this document, I hereby agree to be the responsible party for payment over this account.

____/____/____ _____
Date Name (printed) Relationship to Patient, if applicable

_____
Name (signature)