Financial Agreement

We the staff of Piscataqua Dental PA thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to the provider – patient relationship. Our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding fees, policies, or responsibilities please feel free to contact Mary Moss at 603.431.4559.

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

Please understand that payments for services are 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 staff.

We make payments as convenient as possible by accepting (cash, money orders, MasterCard, Visa, Discover, checks, and Care Credit). A $10.00 fee will be charged for all returned checks.

Interest

Interest will incur if a balance remains unpaid after 30 days.

Insurance

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 benefit under your policy. We have learned 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 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 plans. When insurance is involved, we are contractually obligated to collect co-payments, co –insurance, and deductibles, as outlined by your insurances 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 contacted with your carrier we will not negotiate reduced fees with your carrier.

Missed Appointments

We require notice of cancelations 48 hours in advance. This allows us to offer the appointment time to another patient. If you fail to keep your scheduled appointment without notifying us in advance, a missed appointment fee will apply. These fees are $50.00 for missed hygiene appointments and $100.00 for missed doctor appointments. Repeated missed appointments without notification may cause you to be discharged from the practice.

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let us know so that we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy and I agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

Signature _____ Date_____