**FINANCIAL POLICY AND AGREEMENT CONSENT FORM**

Thank you for choosing **Scott E. Learn, D.M.D**. for your dental needs. We are committed to providing you with excellent care at affordable prices. Our financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees, and patients' financial capabilities. To provide you with the most beneficial and comprehensive service and care, we request you to review and complete our office and financial policy consent form. We will be happy to answer any questions you may have regarding the proposed treatment and available financial options.

**Non-Insurance (Cash) Payment:**

Non-Coverage Payments are due in full at the time of service, unless prior financial services are made. I agree to be responsible for payment of ALL services rendered on my behalf or my dependents. In the event that payments are not received by agreed upon dates, I understand that a 1½ per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days unless previously written financial arrangements are satisfied. Fees that are incurred to collect payments will be billed to and payable by the patient's account holder.

**We do offer several payment options:**

- **Cash or Check**
- **Visa, MasterCard, Discover, HAS, HFA**
- **Healthcare Financing Company(OCA)**

**Insurance & Co-Pays:**

Estimated Co-Payments vary based on the information provided by your insurance provider. Our friendly staff will be glad to assist you in letting you know what your estimated co-payment amount is for each of your visits. You are responsible of any services not covered by your insurance. Our office is committed to helping patients maximize their benefits. If you have any questions, our courteous staff is always available to answer your questions.

- We will always do our best to help you to maximize your benefits.
- Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.
- Your treatment plan is individually tailored to your needs and is not based on your dental insurance benefits or lack of benefits.
- Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions to your policy. We cannot act as a mediator with the carrier or your employer.
- Our staff is trained to help you with questions you may have relating to how your claim was filed, or regarding any additional information, your carrier may need to process your claim.
- As a courtesy to all of our insured patients, we will file your dental insurance claim forms. You are responsible at the time of treatment for payment to us of any applicable deductible and for your co-insurance portion. Any payments made directly to you by your insurance company on unpaid balances should be forwarded immediately to our office so that your account may be credited.
- Your claim will be filed immediately, and benefits are expected are to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self-pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.

**Credit Card Processing Fee:** A credit card processing fee of 3% will be applied to all payments made by credit or debit card. This fee helps to cover the merchant service charges imposed by our payment processors and ensures we can continue to offer convenient electronic payment options. Customers are welcome to avoid this fee by choosing an alternative payment such as cash or check. This policy is in compliance with state and federal laws regarding surcharging.

**Canceled and Missed Appointments:**

- We require a 48 hour notice to cancel or reschedule an appointment to avoid a fee.
- Appointments canceled or rescheduled without a 48hour notice are subject to a $100.00 fee and will need to be paid prior to rescheduling.
- You may be asked to pay your co-payment in advance to reserve or future appointments.
- A credit card on file may be required to schedule future appointments.

**Returned Checks:**

- Any check returned by your bank is subject to a $50.00 returned check fee. The fee including check amount is due immediately. A cash payment, in full, is the only payment accepted.

Please feel free to contact your insurance company regarding unpaid benefits. We will gladly provide you with a letter which would include all pertinent information which you may sign and mail. I understand and accept the financial and the dental insurance policies listed above and have had any and all questions Answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described.

**Delinquent Accounts**: Balances remaining unpaid after 90days from the date of service (or final insurance payment) are considered delinquent. If a balance remains unpaid despite reasonable attempts to contact you, your account may be referred to a third-party collection agency or the local magistrate. In this event, you acknowledge and authorize the release of necessary personal information to the agency for the purpose of securing payment. A $35.00 monthly late fee will be applied to any balance that remains unpaid after the insurance company has made its final determination. The fee will continue to accrue each month until the remaining balance is paid in full.

**Collection Fee Policy**: Any collection fees, legal fees, or additional costs incurred in the process of collecting an unpaid balance will be the responsibility of the patient. These fees will be added to the patient's account balance if outside collection series become necessary.

**Refund Policy:**

All payments collected on date of service may be refunded same day. Refunds Request after date of service will be processed within 45 days of refund submission form. Please note ALL PENDING INSURANCE CLAIMS must be paid by your insurance company before a refund may be made.

**Acknowledgement of Insurance Payment Authorization:**

I hereby authorize and direct payment of my insurance benefits to be paid for services rendered directly to Scott E. Learn, D.M.D. In the event that the insurance company misdirects payment to me, I understand that I am responsible to IMMEDIATELY remit such payment to Scott E. Learn, D.M.D. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I authorize the release of information as necessary to process insurance claims and, if applicable, for collections purposes as described above. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s) and/or agency to secure payment. This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Print- Patient, Parent, or Legal Guardian Signature Relationship

_____ _____

Signature Date