

Dentistry Today

E. Dale Behner, DDS

Financial Menu

Thank you for choosing our practice for your family dental care. Our goal for our patients is to experience a pleasant dental environment, while providing the finest care available. We strive to keep our patient families well informed of their dental needs, treatment alternatives, as well as financial options to make your total dental experience as comfortable as possible. This menu is designed to help you better understand our financial policies.

Payment

Payment is expected the day dental services are provided. For your convenience Master Card, Visa, Discover, American Express, debit cards, checks and cash are accepted. We will inform you of your estimated dental fees, deductible and co-payment due to begin treatment as dental needs are diagnosed. If extended payments are necessary, please discuss this need prior to treatment with our Financial Coordinator.

Dental Insurance

If you have the benefit of dental insurance, we accept most Insurance plans that do not require a specific provider. Please bring your identification card, signed insurance form and benefit booklet to your first visit. As a courtesy, we will file your dental insurance claims. Please be prepared to pay your deductible and any estimated co-payment as services are rendered. If you anticipate an inability to remit payment as arranged, please inform our office immediately.

Insurance Payment

As a courtesy, we will file your Insurance claims and are willing to wait up to 60 days from date of service for the insurance to respond. We will contact your carrier if a payment delay is noted and strive to resolve the situation. If unable to immediately resolve the insurance delay, a statement will be forwarded to you and payment is due in full. Dental insurance is not intended to be a "pay-all" service, but to help reduce your "out-of-pocket" expenses. We must emphasize as a healthcare provider; our relationship is with you, not your insurance company. Our concern is for your well being and structure our services accordingly. Insurance companies determine benefit packages and payment rates (usual and customary fees - UCR) by the type of plan that is purchased by the employer/insured party – not the level of care the office is providing. All charges are your responsibility from the date services are rendered, regardless of insurance benefits, arbitrary determination of UCR payment, or lack thereof.

Appointments

We see patients on a "by appointment" basis and ask you to call in advance to reserve time for your family. We value your busy schedule and strive to see patients at their appointed time, we ask you to extend the same courtesy. If a scheduling conflict occurs with a reserved appointment, please contact our office at least 48 hours in advance for appointment changes. This notice provides the opportunity to serve others who are in need of dental care. In instances where appointments are cancelled or missed with 24 hours notice or less, a minimum missed appointment fee of \$45 may be charged to your account. This fee must be paid prior to the next dental visit.

Returned Check Fee

A fee of \$25.00 will be charged for any returned check. After two returned checks are received, the account will be placed on a "cash only" basis. The outstanding balance and returned check fee must be paid immediately upon notification from our practice and prior to the next scheduled appointment.

Acknowledgement and Authority

I consent to treatment as necessary or desirable for the patient named, including but not restricted to drugs, medicine, performance of operations & conduct of laboratory, x-ray, or other studies that may be used by the attending Doctor, staff or qualified designate. I authorize Dental Care Today, PC to release any information to a third party &/or health practitioners. I authorize & request my insurance company to pay Dental Care Today, PC directly, otherwise payable to me. I understand my insurance carrier may pay less than the total bill for services & unconditionally agree to be responsible for and to pay all charges incurred on my behalf or my dependants. I unconditionally agree to be responsible for and to pay Dental Care Today, PC for any and all incurred charges. In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial arrangements made at the time of discharge or if no such arrangement are made, then payment shall be made in full within thirty (30) days of discharge. I/we agree that in the event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the balance, reasonable attorney fees & incidental expenses shall be added to the amount due on the account, plus any applicable court costs. I further understand a 1 1/2 % finance charge per month (18% annually) will be added to my account for any balance over 60 days, regardless of pending insurance claims. I agree to pay Dental Care Today, PC a minimum fee of \$45.00 for any appointment scheduled and missed or cancelled with 24 hours or less notice. The information I have given today is correct to the best of my knowledge. I also understand this information will be held in confidence and it is my responsibility to inform Dental Care Today, PC of any changes in my personal or medical status. I authorize Dental Care Today, PC or qualified designate to perform dental services that I may need during diagnosis and treatment with my informed consent. If the patient is a minor, I certify I am the legal guardian and consent to treatment on their behalf.

Name (Printed) _____ Date _____

Signature _____ Date _____

My signature confirms I am legally the Responsible Party, Parent or Authorized Guardian for the patient listed above.