cottonwood DENTAL

Financial and Insurance Information

- Taking care of you and your family is our highest priority. Your individual needs are always considered, your choices respected.

- We must emphasize that as dental care providers, our relationship is with **YOU,** not your insurance company. While filing of insurance is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. All charges that are incurred are your responsibility regardless of your insurance coverage. Our practice will not enter into any disputes with your insurance company over any claim.

- When it comes to talking about finances, our goal is to provide you with a clear understanding of our dental fees and payment options. We will provide you with an ***estimate*** of the total fees expected. Please understand this is only an ***estimate.*** Treatment needs can change for a variety of unforeseen reasons.

- Not all services are covered benefits in all contracts. Every patient's dental plan is different, and ***necessary*** dental services are not necessarily covered. Some contracts arbitrarily select certain services they will not cover. Very few dental plans fully cover all dental services.

- Returned checks are subject to a $42 NSF fee. Balances over 60 days from the date of service will be subject to finance charges (1.5% per month or 18% annually).

- Failed appointments or appointments cancelled without 48-hour advance notice, will be subject to a $25 fee as we reserve this appointment time for you.

- If you fail or no show your scheduled appointment two or more times you will be charged a reservation fee determined by the office on case by case basis to reschedule your appointment. If you do not keep your appointment at that time you will forfeit the fee. If you do attend your scheduled appointment it will be applied to the services rendered.

- Patients with **NO** insurance coverage, who pay in full with either ***cash or check***, at the time of service, will be given a 5% bookkeeping courtesy.

- Should the party default, they will be responsible for all reasonable Collection charges and Attorney fees incurred by the creditor as a result of recovery efforts to collect the debt. The collection charges result from the cost s associated with the third party recovery.

Financial and Insurance Information II

Occasionally, patients in our office here at Cottonwood Dental request procedures that are not covered by their dental plan. We are happy to provide these services, but want our patients to understand the financial implications.

For example, a patient may request a porcelain crown or filling but their dental plan only covers a metal crown or filling. The insurance company will calculate the benefit to you on the Explanation of Benefits (EOB) sheet, based upon a similar procedure covered by the plan, often referred as an "alternate benefit." However, you received a procedure that was not covered by your dental plan. Therefore, we are allowed to bill you the difference between the benefit calculated on the EOB and our office fee for that procedure.

In 2012, the Legislature modified *Prohibited Acts for Fees charged for dental services*§ 44-7,105, prohibiting an insurance company from attempting to limit the fee a dental office could charge a patient even though the dental plan did not cover a particular procedure sought by the patient.

You are not covered for any services that otherwise would qualify as Covered Service, but which your dental benefit plan does not reimburse to some extent. This may include services not reimbursed because of applicable deductibles, copayments, coinsurance, benefit maximums, waiting periods, alternate benefits and frequency limitations.

We would be happy to provide you the procedure that is covered by your dental plan. However, if you choose to receive a higher level procedure that is not covered by your plan, we will need to bill you for the difference between your plan benefit and our office fee.

We appreciate your understanding and acknowledgement of this situation.

I have read and understand the Financial Policy of Cottonwood Dental.

I authorize my insurance company to pay my dental benefits directly to the practice.

Signature:_____ Date:_____