Integrated Dental Arts, PLLC
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Financial Responsibility Policy

Our responsibility:

- To help resolve any financial and/or treatment inquiries for you.
- To assist in billing claims to your insurance carrier(s) in a timely manner on your behalf.
- To assist you in resolving any questions with your bill, including claim payment.
- To refund you in a timely fashion if any credit were to remain after your insurance pays its portion of your treatment.

Your responsibility:

- To pay for treatment rendered at the time of service
- To provide us with current and accurate information to submit your claims correctly.
- To pay your co-payment, estimated coinsurance and/or deductible at the time of service.
- If you are insured, to pay any balance estimated at the time of service as well as any balance remaining after insurance pays their portion, according to the contracted agreement.

Payment:

- We accept cash, personal checks, and credit cards (MC, VISA, DISCOVER, AMEX).
- For private pay parties paying with cash or check, we offer a 5% courtesy reduction for prepayment of scheduled service(s).
- Arrangements with outside financing (CareCredit and Wells Fargo) is available for qualified patients.
- Balances older than 60 days may be subject to additional collection fees and interest charges of 1% per month. Interest rates will be waived if a prepayment plan is set up on auto pay to a credit card.
- Returned checks will be charged a $30 fee. In addition, if 2 or more checks are returned by your bank you will be required to use another form of payment.

The office of Integrated Dental Arts, PLLC participates and assists patients with many insurance plans. If your insurance plan is one that we participate with, our billing office will submit a claim for services rendered. Based on the coverage you and/or your employer selected, there may be some (or all) services you receive that may be non-covered, have reached your yearly maximum, or considered not medically necessary. Please be aware those balances are your responsibility and are due at time of service. Many patients believe that if they have insurance, it is the insurance company that owes our office for their services. This is **not** the case. **The insurance contract is between you, your employer and the insurance company; our relationship to you is as a health care professional.** We will collect applicable co-pays and estimates of coinsurance and deductibles at the time of service.
_________ Initial Here

Account Balance:
Any outstanding balances are due within 30 days (after the insurance pays). Delinquent account and unpaid balances may result in referral to our collection agency. **We do our best to estimate what your insurance will cover and what you will owe for services rendered. Please note this is never a guarantee. If for any reason the insurance does not pay their estimated portion, it is your responsibility to pay any remaining balance.** Future appointments may be refused or postponed until all balances are paid. A delinquent account could also result in dismissal from our practice. Please contact our front office with any questions you have regarding your account balance. **________ Initial Here**

Late Cancellation and No-Show Policy:
We strive to provide you and the rest of our patients with exceptional dental care. In an attempt to remain consistent with this, we have implemented an appointment cancellation policy that allows us to accurately and appropriately schedule appointments for all patients. When an appointment is scheduled, that time has been reserved for you and when it is missed, that time cannot be used to treat another patient.

If an appointment is cancelled within 48 hours (2 business days) or missed, a minimum$50/hr deposit may be required when scheduling future appointments. This deposit will be applied to your account or may be refundable if cancellation is provided prior to the 48 hour policy.

Prepayment to reserve operatory time is required for all sedation visits and longer procedures at the discretion of Integrated Dental Arts. _________ Initial Here

I acknowledge receipt of Integrated Dental Arts, PLLC patient financial policy and have ready, understand and agree to comply with these policies.

Date: ___________________________

Name: ____

Signature: ____