DAVIDSON DENTAL ASSOCIATES

Thank you for choosing Davidson Dental Associates. Our expert team of dentists, hygienists, and dental assistants look forward to serving all your dental needs. We have found that a clear understanding of what your dental needs are and the financial responsibility for your care are very important. Our policy is to provide each patient with a written estimate of recommended treatment. Our business staff will provide you with *estimated cost* of your treatment; however, we do encourage all patients to familiarize themselves with their insurance policies.

OFFICE AND FINANCIAL POLICIES

1. Davidson Dental Associates requires that each patient per visit complete our patient verification form.

2. Davidson Dental Associates expects that **all patient co-payments are due at the time services are rendered**. We do offer outside financing for extensive treatment. Financing is subject to approval by a participating financial group. For your convenience, we accept Cash, Personal Checks, MasterCard, Visa, American Express, and Debit Cards.

3. All patients having an existing account balance that are past due **will not** be rendered service until balance has been satisfied. All future treatment will be placed on hold until balance is paid in full. Any patient who has not paid their account in full will be subject to a $15 monthly late fee plus 1.5% monthly finance charge. **If it becomes necessary to refer your account to a collection agency, you will be responsible for collection fees of 33.3% the balance due plus reasonable attorney fees and costs.**

   _____**(initials)**

4. All collection lawsuits initiated by our attorneys will be in the state of Maryland. Maryland law shall control all such actions.

   _____**(initials)**

5. Davidson Dental Associates charges a thirty-dollar ($30.00) fee for returned checks.

6. Davidson Dental Associates reserves the right to obtain credit reports on patients when necessary.

   _____**(initials)**

7. Any patient who defaults on a payment arrangement by 10 days beyond the contractual date will be expected to pay the balance in full immediately.

8. Davidson Dental Associates reserves the right to charge for broken and cancelled appointments. 24 hours cancellation notice is required for all appointments. Additionally, if we have not received a verbal confirmation by 2pm the business day prior to your scheduled appointment, your appointment will automatically be cancelled and you will need to reschedule. No show patients and same day cancellations will be charged a cancellation fee of $75 or more (based on a fee of $25 for every 15 minutes of your scheduled appointment.)

9. Davidson Dental Associates does not extend courtesy discounts to anyone.

10. All patients, under the age of eighteen, **must** be accompanied by parent or guardian who must remain on site while treatment is rendered to minor.

11. The parent or guardian of the minor will be responsible for all open balances of the minor.

    _____**(initials)**

12. Requests for Release of Documents and copies of x-rays will be completed within 15 days of request. $25 fee for copies need to be paid at time of request.

13. **Insurance balances are ultimately the patient's obligation. We file (most) insurances at no cost to you as a <u>courtesy</u>. We are glad to offer this service; however, insurance balances that are not paid after 60 days WILL be billed directly to you. Please keep your walk out statements and follow up with your insurance company to ensure that payment is in process. UNPAID BALANCES ARE YOUR RESPONSIBILITY AND NOT THAT OF YOUR INSURANCE CARRIER. YOU ARE ULTIMATELY RESPONSIBLE FOR THE YOUR ENTIRE BALANCE. ALL DISCREPANCIES IN PAYMENTS OR LACK OF PAYMENTS BETWEEN YOUR INSURANCE CARRIER AND YOU ARE YOUR RESPONSIBILITY.**

    _____(initials)

14. **FURTHER YOUR INSURANCE PROVIDER MAY ONLY COVER A PORTION OF YOUR TOTAL BALANCE, RECIPET OF PARTIAL PAYMENT FROM YOUR CARRIER DOES NOT MEAN THAT YOUR BALANCE IS PAID IN FULL; YOU REMAIN RESPONSIBLE FOR THE DIFFERENCE BETWEEN EXPENSES PAID FOR BY YOUR INSURANCE AND THE ACTUAL BALANCE.**

    _____(initials)

INSURANCE POLICIES

1. Dental benefits are based on a contract **between your company's insurance administrator and the individual participating in the plan. It is your responsibility to have yourself assigned to the correct dental site**.

2. **It is your responsibility to be familiar with restrictions, limitations and deductions that may apply to your plan.**

3. **All deductible or co-payment amounts must be satisfied at the time treatment is rendered**. The requested amount of co-payment is estimated on the information received from your insurance company. All claims that are rejected or adjusted by the insurance company will become your additional responsibility and payable to Davidson Dental Associates immediately.

4. Patients who have insurance companies, of which Davidson Dental Associates is not a participant, will be expected to pay the full amount of treatment at time of service. We will provide you with a statement of service to submit to your insurance carrier once balance is paid in full.

    _____(initials)

5. Except for federal government, Davidson Dental will only accept and submit to one insurance company.

COORDINATION OF BENEFITS

Davidson Dental Associates will submit only to your primary insurance company, using the primary guarantor and birthday policies. We will gladly provide you with a statement of service to submit to your secondary insurance company.

_____ _____

SIGNATURE OF PATIENT DATE

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE