PAYMENT POLICY

1. SELF-PAY (no insurance): Payment in full is expected at the time of service, unless other arrangements are made before the services are provided. Our Billing Department will be happy to speak with you regarding your account prior to your appointment, either by telephone or in person at the office.

2. INSURANCE (out -of-network): PPO: We will file your insurance claim as a courtesy to you, but your personal responsibility (co-insurance and deductible) will be higher than if you receive services from an in-network physician. If your insurance company denies payment for services, you will be responsible for full payment of the balance due.

3. HMO: Most HMO plans do not have benefits for out-of-network services. Please verify if your insurance plan has out-of-network benefits. If there are no out-of-network benefits available, your account will be subject to the "self-pay" guidelines.

4. INSURANCE (in-network):
Our office is not responsible for obtaining payment from your insurance company. We will file your insurance claim as a courtesy to you; however, your insurance policy is a contract between you and your insurance company, and payment for services rendered is ultimately your responsibility. If your insurance claim has not been paid within 45 days, you will need to contact your insurance company to inquire about the delay. If your claim remains unpaid after 60 days it will be considered past due, and we will expect prompt personal payment of the balance due. Accounts left unpaid over 90 days will be turned over to a collection agency and reported to credit bureau.

5. A $25 fee will be applied to your account for any returned checks.

6. CANCELLATION POLICY: If you are unable to keep your appointment, we require 48 hours notice, or we will consider it a "late cancellation". This courtesy allows us to be of service to other patients. A fee of $25 will be assessed for late cancellations and no-shows. This fee may be waived at our discretion if there are unusual circumstances that prevented you from canceling your appointment in a timely fashion. If a fee is accessed, it must be paid prior to your ability to schedule and receive future elective services at our office.

7. Please be aware that a parent bringing their child to our office for dental care is legally responsible for payments of all charges. All treatment proposals must be signed and approved by parent/guardian for anyone 17 years of age or under prior to treatment.

8. I authorize and request my insurance company to pay directly to the dentists or dental group, insurance benefits otherwise payable to me.

9. I authorize the dental group to release my information, including diagnosis and records of treatments, examinations rendered to myself or to my child during the period of such dental care, to third party payers and / or other health care practitioners.

Signature: ____

Date: ________________________

OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice.

The Doctors of Antioch Dental Group are sensitive to the rising cost of living, including health and dental care. For this reason, we offer 0% financing to our patients. If the cost of dental care has previously been an obstacle for getting your mouth in good repair, then ask one of our staff members to explain our financing programs.

Applying for our financing option only takes a few minutes and there is no fee to apply.