Bethesda Family Dentistry
Patient Financial Policy & Consent to Treatment

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. We need *your* assistance and *your* understanding of our payment policy. Your insurance contract is between you, your employer, and the insurance company. Not all services are covered by all contracts. While the filing of insurance claims for participating insurance carriers is a contractual obligation of the practice, all fees are ultimately the patient's responsibility. We will be happy to help you process your insurance claim form for reimbursements. If payment is not received within 30 days, we will send you a statement and payment will be expected at that time. This office cannot accept responsibility for negotiating a settlement on a disputed claim. If we do not participate in your insurance plan, you may still choose to be seen by the practice.

Payment in full is due on the date of service, the day treatment has begun. Payment can be made by cash, checks, or credit cards. A fee of $35.00 will be charged for checks returned for insufficient funds. An additional monthly fee will be charged on all past due accounts. understand and agree that I am responsible for any amount charged for dental services to me, my dependants, or relatives not paid by my insurance.

We will gladly file your insurance claim form and will accept assignment for payments directly to us, provided you have supplied complete information. All estimate amounts not covered by insurance are due and payable at the time of service. Any amounts estimated as patient co-pay amounts, are estimates only. Any estimated co-pay amount paid, which result in a overpayment, will be automatically credited to this account for future work or at the patients written request be refunded to the patient. As a courtesy to you, we will provide you with the documentation necessary for you to file with your insurance carrier.

Outstanding balances will incur a monthly finance charge of 18 percent annually or 1.5 percent monthly. Our billing service will automatically apply this charge to all accounts beginning at 90 days past due. In the event my account is overdue, I understand that I will be subject to any and all reasonable attorney fees, costs, and miscellaneous costs incurred in the process of collecting a debt. Accounts outstanding over 120 days may be referred to collections.

I hereby authorize the professionals at Bethesda Family Dentistry to furnish account information by electronic, postal, or other means, to insurance carriers or other payment agents concerning all previous and future dental treatment, and hereby assign to the dentist, payment for dental services rendered to me, my dependants, or relatives. I authorize Bethesda Family Dentistry to furnish account and treatment information to other associates, legal professionals and technical support personnel utilized by this office in the normal course of business activity. I authorize this office to take photographs and radiographs for diagnostic records, professional guarantee either expressed or implied, as a result of work done in office.

All patients are required to submit photo identification at the time of registration in accordance

developed to be compliant with the Federal Trade Commission's Red Flag Rules. We require 24 hour notice if you wish to cancel or change your appointment. A $37.00 fee may be assessed for appointments missed without notice. We encourage you to contact us promptly for assistance in the management of your account.
We are here to help you, and will be happy to answer any questions you may have about your treatment or insurance coverage. The authorizations within this document are valid after the date of last treatment by this office. I am eighteen (18) years of age or older. I consent to the treatment. All of the above is understood and agreed.

In signing this acknowledgment form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

By signing below you are agreeing to the terms above, as they are written and without modifications and are providing Bethesda Family Dentistry consent to provide treatment.

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(Signature of Patient, Policy Holder or Legal Guardian) (Date)