Financial Policy

Thank you for choosing Advanced Dental and Dentures to provide your dental care. Our staff is committed to providing you with the best, most comfortable care possible. We also want to make clear our policies to ensure you have a great experence.

**Payments and Appointments** (Initial\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. Full payment is expected at time of service. For insurance, your portion minus estimated insurance is due up front.
2. We know dental treatment can be an unexpected expense and offer several financing options to help meet this unbudgeted expense. We also accept all major credit cards, checks, and cash.
3. There will be a service charge for all returned checks or stop payment checks of $150 plus any costs associated with the returned check or stop payment incurred by Advanced Dental and Dentures & Associates.
4. **Any appointment that needs to be cancelled must be done at least 24 hours in advance; there will be a fee of $50 per appointment (initial) \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insurance** (Initial\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. **Insurance is the full responsibility of the patient not Advanced Dental and Dentures**. It is a contract entered into by yourself and the insurance provider. Advanced Dental and Dentures does not enter into dispute with any insurance company over any claim. We will try to provide all the proper forms and paper work needed to pay the claim but will not take responsibility for failure to pay for any reason; even if the insurance company states they did not receive the paperwork. It is the responsibility of the patient to make sure the insurance pays.
2. After your insurance provider has processed your claim (about 30 days) you will receive a statement showing the amount due. **Payment is due 14 days after the insurances pays and will be collected according to the Credit card authorization form on file.**
3. Patients are responsible for all fees over the “Usual, Customary, and Reasonable” posted by their insurance provider. Smile Designs does not hold to the U.C.R set by insurance. U.C.R is different per insurance provider and not a set standard.

**Lab work, Treatment and Radiographs (X-rays)** (Initial\_\_\_\_\_\_\_\_\_\_\_\_\_)

1. All lab work not completed within 30 days from the start date due to any reason, at no fault of Advanced Dental and Dentures will be considered abandoned treatment. The balance is still due and will be sent to collections. Lab work will not be held past 90 days.
2. All lab work is billed to the patient and insurance when started. This is the medical and ADA standard.
3. **All treatment is billed in full when started**. Any patient not wanting to finish treatment for whatever reason is still responsible for payment in full, not a partial amount. The dentist has finished the work minus cementing the completed restorative work. We still have to pay the lab, shipping, staff, etc., and consider the work abandoned.
4. **Refunds will not be issued for uncompleted or abandoned treatment**. All money paid will be applied to administration, consultation, lab, shipping, staff and doctors chair time fees. All prepaid money for future treatment is nonrefundable and will be treated as a credit that may be transferred to immediate family members.
5. Radiographs by Florida State law must be kept by the dental office and are the property of the dental office not the patient. You are entitled to a copy but will be charged $25 for duplication. If your x-rays are digital and able to be emailed we will email them to another dentist at no charge with authorization from the new treating dentist.

I have read and understand the policies outlined above. I have been given the opportunity to ask questions concerning Advanced Dental and Dentures Financial policy and have had all questions answered to my satisfaction and agree to the policies above. I further agree that any suit, action, or proceeding with respect to this Agreement shall be brought in the courts of Jacksonville “Duval County”, in the State of Florida or in the U.S. District Court for the Middle District Court “Jacksonville Division” of Florida.

Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

In an effort to better serve our patients and simplify your billing experience Advanced Dental & Dentures offers credit card acceptance. Accounts on file can be charged either as a one-time payment on request or as back up payment in the event of a past due balance with the Office. Your card information will be held on a highly encrypted, secure medical grade server, designed to handle extremely private medical data that exceeds all HIPA regulations for such sensitive data.

You are authorizing **Advanced Dental & Dentures** to maintain your card information on file to cover the financial responsibility after insurance. If you choose not to participate all charges will be due in advance and we will help you self-bill your insurance. You may also request a pre-determination from your insurance company before we proceed.

Credit/Debit Information

Patients Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

Card Holders Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Holders Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_

Check Card Type | **□** Credit | **□** Debit | **□**HSA | **□** Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number \_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_|\_\_\_\_\_\_\_\_\_\_ Exp. Date \_\_\_\_\_\_/\_\_\_\_\_\_ 3 Digit V Code \_\_\_\_\_\_\_\_\_\_

Choose Billing Option

**\_\_\_\_\_\_\_\_\_\_ (initial Option 1)** I authorize **Advanced Dental & Dentures** to charge any account balance in full after the insurance has paid its portion to the card on file.

**\_\_\_\_\_\_\_\_\_\_ (initial Option 2)** I choose to manually pay any account balance after insurance. Charges not covered by insurance are due 14 days after the insurance pays its portion. After 14 days if the account is past due it will be charged a late fee of $25 and account balances will automatically be charged to the card on file after 21 days past due.

Personal Guarantee and Authorization

I authorize **Advanced Dental & Dentures** to charge my credit card in agreement with the billing option I selected above. I guarantee the performance of the finical provision of this agreement. After payment by credit card, you agree not to cancel, revoke or charge back the contracted and authorized charge on your credit card by **Advanced Dental & Dentures**. If you do so, and it is later determined that the charge was properly authorized, you agree to pay all out of pocket fees and costs incurred by **Advanced Dental & Dentures** as a result of the improper cancellation, revocation, charge back, or dispute. I also agree that insurance is a contract between myself and the insurance and not **Advanced Dental & Dentures** and the insurance. We bill insurance as a courtesy to you but do not enter into dispute as to lack of payment.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**ALL PATIENTS PLEASE READ AND SIGN THE ACKNOWLEDGEMENT BELOW**

**All professional services rendered** **are charged directly to the patients and are responsible for payment of fees** regardless of insurance coverage and or benefits.

I understand and agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan.

I authorize release of any information relating to dental claims.

I hereby authorize insurance payments directly to Advanced Dental and Dentures & Associates.

Advanced Dental & Dentures will be glad to file claims on your behalf to your insurance company; However some companies do have limitations on coverage and may require additional information to be provided by the patient.

I understand that no insurance company guarantees benefits or payment of claims, some claims may be reviewed by dental consultants, possible downgrades in materials covered or completely denied.

**Collections and Refunds:** Accounts sent to collections will be responsible for costs associated with such action. Including but not limited to services fees, collection fees, interest, postage, phone calls, court cost, plus all cost that Advanced Dental and Dentures may incur collecting delinquent accounts. No refunds will be issued for uncompleted or abandoned treatment.

All monies paid regarding uncompleted or abandoned treatment will be applied to administration costs and Doctors consultation fees. All prepaid monies for future treatment is nonrefundable and will be treated as uncompleted and or abandoned treatment.

If you agree to begin treatment and then decide to abandon the treatment plan, any materials used (impression, xrays, lab fees, etc) will be deducted from amounts paid prior to any refunds being authorized by management.

Prefered Pharmacy Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PhoneNumber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read and fully understand all of the above information regarding dental insurance and claims filing. I have had the opportunity to speak with staff members to clarify any questions I may have. I understand that I am fully responsible for all charges incurred regardless of my dental insurance benefits and coverage.

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Patient/ Responsible Party Signature DATE