Ferncreek Family Dentistry

Ngozika Daka, DMD, PA

Thank you for choosing our practice. This agreement is provided to you to clarify our payment policies. Please read it, ask any question you may have, and then sign in the space provided. Our receptionist will provide you with a copy at your request.

- **Insurance.** We are participating providers for Delta Dental Federal Services and United Concordia Companies, Inc. Remember that dental insurance is a contract between the patient and the insurance carrier, not between the insurance carrier and the dentist. **Knowledge of your insurance benefits is <u>your</u> responsibility**. Please contact your insurance company with any questions you may have regarding your coverage. **Any unpaid balance by the insurance company is the patient's responsibility.**
- **Co-payments and deductibles.** All co-payments, co-insurance and/or deductibles must be paid *at the time of service*. Our office accepts Visa, Master Card, American Express, Care Credit, and Discover Card as well as cash, checks and money orders.
- **Non-Covered Services.** Please be aware that certain procedures may not be covered by insurance. *If services are not covered by your insurance or if you do not have insurance, payment is expected at time of service unless payment arrangements were made in advance.*
- **Proof of Insurance.** We will ask to make a copy of your insurance card and ask that you complete our patient information forms before being seen by a doctor of hygienist. We are required by law to ask for a photo identification to verify your identity.
- **Claims of Submission.** We will submit your claims, as a courtesy, for you to your insurance company of choice. We will, within reason, attempt to help you get your insurance claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **If payment is not received within 60 days, the entire balance will be your responsibility.**
- **Coverage Changes.** Insurance companies have very strict requirements with regard to filling deadlines for reimbursement of claims. Please notify us immediately of any insurance changes. If your insurance company does not pay your claims in 60 days, the balance will be automatically billed to you and payment expected within 10 days of that billing.
- **Missed Appointments.** If you are unable to keep your appointment, please notify our office <u>24 hours in advance</u>. Failure to do so deprives other patients the opportunity to be seen and will result in a fee for broken appointment. This includes canceling the day of appointment or a no show. At that time, Ferncreek Family Dentistry, will waive the first missed appointment but the second offense will be a $25 charge.
- **Late Payments.** An interest charge of 1.5% (18% annum) per month is assessed to all accounts that are past due. Failure to pay your bill within 120 days will result in your account being turned over to a collection agency and reporting to credit bureaus. **<u>A fee of 30% of your balance may also be applied towards your amount owed if your account is sent to a collections agency.</u>**
- **Non-sufficient Funds.** There will be a $35.00 fee for any returned check.

I have read and understand the financial policy and agree to abide by its guidelines. I understand that, if I am head of household, this agreement covers my entire household.

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Patient of Guardian Name (Printed) Date

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Patient or Guardian Signature