

GREGORY T. ENGEL, DMD, MS

FINANCIAL POLICY

PLEASE READ THOROUGHLY AND INITIAL THE HIGHLIGHTED AREAS!

We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care needed to enjoy a healthy and confident smile with respect to your budget. We accept cash, personal check, all major credit cards, and CareCredit.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage. However, **WE CANNOT GUARANTEE ANY ESTIMATED COVERAGE**. Because the insurance policy is an agreement between you and the insurance company, **YOU** are directly responsible for all charges. Please know that we will do everything possible to see that you receive the maximum benefits from your policy. Insurance is filed the day of your visit with the information you provide in this paperwork.

PAYMENTS DUE UPON TREATMENT

*****Please INITIAL highlighted areas*****

_____ For no insurance, payment is expected **in full** at time of treatment.

_____ For participating insurances –**Plan participation verification is required. Applicable out of pocket is to be paid at the time of treatment. This amount is solely an estimate based on available plan verification. You will be responsible for any remaining balance after insurance pays.**

_____ For nonparticipating insurances – payment is expected **in full** at time of treatment. We will file the claim as a courtesy to you.

_____ **CBCT scans, CBCT scan interpretation (if scan originates from an outside office), intraorifice barriers, interim direct restorations (for GentleWave® use), post space preparations, canal obstructions, incision & drainage procedures, incomplete root canal treatment (fracture discovery), and resin restorations may not be covered benefits with your specific insurance plan. Many insurance plans choose to 'bundle' these codes without transparency. You, as the insured, are responsible for any remaining balance after an insurance claim is filed and resolved.**

OTHER FEES

NO SHOWS –As a courtesy, our office will remind you of your treatment appointment in advance. If you do not show at your scheduled time without 1 business day prior notification to our office, you will be assessed an \$85 no show fee. Your insurance will not cover this fee.

PARTIAL TREATMENT – If you begin endodontic therapy and then choose on your own recognizance not to complete treatment, you are responsible for the appropriate half-treatment fee, and all subsequent possible oral health complications.

In order to complete treatment and give insurance companies a reasonable amount of time to make payment, there will be no finance charge for the first 60 days after the start of treatment. Any account with a balance after 60 days will be subject to a finance charge of 1.5% per month (18% APR) as well as any expenses that may be incurred collecting past due accounts including 33 1/3% attorney fees, court costs and interest. Any checks returned to us will be charged a \$35 returned check fee.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE. I HEREBY AUTHORIZE BEACH ENDODONTICS TO FILE DENTAL INSURANCE ON MY BEHALF AND AUTHORIZE PAYMENT DIRECTLY TO BEACH ENDODONTICS FOR THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. **I AM AWARE THAT I AM RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY INSURANCE COMPANY.**

_____ / _____

PATIENT OR RESPONSIBLE PARTY SIGNATURE

DATE