DENTAL HOUSE
DENTAL EXCELLENCE · COMPASSIONATE CARE

A Dental Office of Janak B. Patel, D.D.S.
2440 Statesville Blvd., Suite 220, Salisbury, NC 28147

FINANCIAL INFORMATION

Dear Valued Patient:

Our practice believes that a good doctor/patient relationship is based on understanding and open communication. We hope that this review of our financial policies will prevent any misunderstandings or disagreements over our payment policies.

Dental Insurance:

As a courtesy to you, we will gladly file your primary dental insurance forms for you. If you have a secondary insurance carrier, we will file these claims for you but you will be require to pay the estimated copay for total treatment cost from your primary dental insurance information. This is done since it is impossible for us to estimate what your secondary insurance carrier will pay toward your dental treatment until we submit to them what your primary insurance company exactly paid. Any overpayments from your primary and secondary insurance companies will be refunded to you.

Dental insurance is a help but insurance companies rarely pay as much or as quickly as you would like. Many insurance policies are written with clauses to help them get out of paying for your treatment. You are responsible for your account, keeping up with your remaining benefits for the year, and informing us of any changes to your dental insurance. Failure on any part of your responsibility may cause late or no insurance payments. Therefore, you will be responsible for treatment costs.

Some insurance companies are transferring dental treatment to your medical insurance coverage. We do not know if your dental insurance company will do this until we file the dental insurance claim to them. We only process dental insurance claims. We do not process medical insurance claims. If your dental claim is denied by your insurance company, you will be responsible for all treatment cost. You will have to file the medical claim yourself and we will provide any assistance we can to help you with this process.

Dental insurance coverage is a contract between you and your insurance company. Your dental treatment is a contract between us and you. We have no direct relationship with your dental insurance company. We will give you the exact cost of dental treatment rendered and an estimate of what your insurance may pay toward this dental treatment, and your portion is due at the time of service. If your insurance company pays less than what we estimated, you will be responsible for the amount due upon a statement from our office. Failure to pay may lead to a late fee, collection agency fee and/or dismissal from the practice.

If your insurance company has not paid within 60 days (2 months) for any claim we have submitted to the insurance company for payment, we will ask you to pay the balance due. We will reimburse you when the insurance company pays us.

Patients Without Insurance:

Patients without dental insurance will be required to **PAY IN FULL** at time of service. **NO EXCEPTIONS**. We do offer finance plans through CareCredit and SimplePay. Please ask for these applications if required before treatment is rendered.

Patients Unable To Provide Proof Of Insurance:

Patients unable to provide proof of insurance will be required to pay in full at time of service. Once you have given us your insurance information, we will file a claim for you. If and when the insurance company pays for any portion of the treatment rendered, we will reimburse you.

For your convenience, we accept cash, checks, MasterCard, Visa and Discover Card. There will be a $25.00 charge for all returned checks. We do offer payment plans in the form of CareCredit and SimplePay. If you are interested in these plans to help pay for dental treatment, please ask us about them.

I understand and agree to fully comply with the financial policies stated above.

_____	_____	_____
Signature	Printed Full Name	Date

DENTAL HOUSE

FINANCIAL INFORMATION

Patient's Full Name_____

SECTION I

Who is **FINANCIALLY RESPONSIBLE** for this patient? (circle one) PATIENT SPOUSE PARENT
Is this person a patient of this dental office: (circle one) YES NO

Responsible Party First Name_____ _____ Responsible Party Last Name_____
Responsible Party Address_____ City_____ State_____ Zip Code_____
Responsible Party Home Phone_____ Responsible Party Work Phone_____ Married Yes No
Responsible Party Social Security Number_____ Responsible Party Birth Date_____
Responsible Party Driver License Number_____ Sex: (circle one) MALE or FEMALE

DENTAL INSURANCE

Do you have **DENTAL INSURANCE**? (circle one) YES NO

If **YES**, please complete **SECTION II** along with the **INSURANCE INFORMATION** section and **READ** the paragraph at the bottom of this page and **SIGN** where it is asks for your signature.

If **NO**, please **READ** the paragraph at the bottom of this page and **SIGN** where it asks for your name.

SECTION II

Who is responsible for this patient's **DENTAL INSURANCE**? (circle one) PATIENT SPOUSE PARENT
Is this person a patient of this clinic? (circle one) YES NO

Insured First Name_____ Insured Last Name_____
Insured Address_____ City_____ State_____ Zip Code_____
Insured Home Phone_____ Insured Work Phone_____ Insured SS#_____
Insured Birth Date_____ Sex: (circle one) Male or Female Insured Married? Yes or No

INSURANCE INFORMATION

What is name of the **DENTAL INSURANCE COMPANY** _____
Insurance Company Address _____ City_____ State_____ Zip Code_____
Insurance Company Phone Number_____ Subscriber ID_____ Group Number_____

What **WORK PLACE** offers this DENTAL INSURANCE
Company Name_____ Company Phone Number_____
Company Address_____ City_____ State_____ Zip Code_____

CONSENT FOR SERVICES

As a condition of your dental treatment by this office, financial agreements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.
All emergency dental services, or any dental services performed without previous financial agreement must be paid in full by cash at time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be guaranteed for a period of six (6) months from the date of the patient examination and limited to the end of the calendar year.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered , or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. If my account is sent to a collection agency due to nonpayment on my behalf, then a collection fee of up to 50% of the balance due will be added to my account balance for administrative and collection costs.

I hereby authorize payment directly to Dr. Patel for any insurance benefits otherwise payable to me for any professional services rendered.

I grant my permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of Person Financially Responsible for this Patient Date Relationship to Patient