

Financial Policy Agreement

Woburn Dental Group P.C.

Welcome to Dr. Jenny Wang's dental office where we are dedicated to serve as your oral health care provider. This Financial Policy Agreement is intended to respect your right to know what to expect, financially, for your treatment, and to maximize our ability to provide excellent service.

Patient's without dental benefit coverage:

We will provide a written estimate for any impending services. Full payment is due at the time of each visit for services rendered.

Patient's with dental benefit coverage:

Please understand that your dental insurance policy is a contract between you, your employer, and your insurance company. Our office is not part of this contract. Our relationship is with you only. Please understand that dental insurance is a benefit to assist with your dental needs. You must familiarize yourself with your dental benefits, including but not limited to the policy start date, your maximum yearly amounts, any limitations or exclusions of coverage, the waiting period, and the coverage percentage for procedures.

Please provide your valid insurance and personal information when you make an appointment. This information will enable our office to verify your dental coverage, and in turn file your dental claims for you. We require that you direct your insurance company to pay your benefits directly to our office by signing the authorization form that is provided on your registration form. Please inform the office immediately if your insurance information has changed since your last visit.

All deductible and estimated co-payments are due at the time of service. We will do our best to give you an estimate according to the "usual and customary fee" offered by your insurance company. Your co-payment may be adjusted depending on the final reconciliation of insurance payments. Services not covered by your insurance are your financial responsibility. In addition, you are fully responsible for any unpaid insurance claim older than 60 days from the date of service.

Patient's who are minors:

The adult(s) accompanying a minor is responsible for payment at the time of service unless charges have been paid, prior to your visit, by cash, check, or pre-authorized to an approved credit card. We cannot treat unaccompanied minors without prior consent obtained from the minor's parent(s) or guardian(s).

Methods of Payment and Discounts:

We accept Cash, Check, Credit Cards (Visa, MasterCard, Discover and American Express), and Debit cards. ***Returned checks are subject to a \$35 charge.***

As a courtesy our office extends the following **discounts** to qualifying patients:

- 1.) For patients 65 and older we offer a 10% Senior Citizen's discount.

- 2.) For all patients we offer a 5% discount when the service exceeds \$500 and the service is paid in full with cash when service is rendered, or with any method of payment at the time of scheduling.

We do not offer extended payment plans, however, we accept the following:

- 1.) **Care Credit**, this is a patient financing company: This plan offers 0% financing for up to 6 months, or up to 24 months with interest.
- 2.) **Pre-Payment Plan**: A patient can deposit as much as he/she can into his/her account prior to services until full payment is complete.
- 3.) If a certain procedure needs **multiple visits** to finish the treatment and the cost is greater than \$500, payment can be split between the number of visits, however, payment must be paid in full before, or at the completion of, the procedure.

Cash discounts will not be extended to patient's utilizing our assignment of benefits on their insurance, except the Senior Citizen's Discount. Only one discount may be applied per person, per visit. Please note that a cash discount will not apply to the above payment plans.

Rescheduling Appointments:

Please understand that your doctors and hygienists have reserved a time for your appointment. Please give our office at least a **48-hour** advanced notice if you cannot keep your appointment. We understand that unexpected events can happen, as a courtesy, we will allow one exception per year, after that we will charge \$50.00 for any Broken Appointment (no show) or any appointment without a 48 hour advanced notice.

Delinquent Accounts:

If an account is not paid in full within **60 days**, including unpaid insurance claims, patient's are responsible to complete payment immediately, otherwise your account will accrue a penalty of 12% APR and be referred for collection. All reasonable collection and/or attorney fees are the patient's responsibility.

Miscellaneous:

If you should need copies of your records and/or x-rays because you are leaving our practice, you must sign a release form and pay a processing fee of \$35.00.

I understand and agree to this financial policy. I have read the policy and agree that a photocopy of the policy shall be rendered effective and valid as the original. Regardless of what insurance coverage I have, I am responsible for the timely payment of my account. The above policy is effective on January 1, 2014.

Signature of Patient or Responsible Party

Date

Patient Name _____