Brookside Family Dentistry Patient Agreement

Welcome to our practice! We are committed to providing you and your family with the best possible dental care. Please read our policies that must be followed in our office and sign below.

The financial obligation for the treatment we render you or your minor dependent is your responsibility. Payment is due at the time of service unless other arrangements have been approved **in advance**. We accept cash, check, credit/debit cards and Care Credit.

We understand your dental insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. We care for patients employed by many different companies. Each employer pays an insurance premium for specific coverage, which fits the company's budget. We encourage to become familiar with your policy exclusions, deductibles, and required co-pays.

We will gladly process your insurance claims by following the American Dental Association guidelines for coding procedures. Please be aware that **your insurance is contract between you and your insurer and we are only submitting <u>your</u> claims**. Dental insurance rarely pays for the entire cost of care. At the time the appointment is scheduled, we will give you an estimate of your insurance benefits based on the information provided by your insurance company. Keep in mind that this is **an estimate only** and depending on what your insurance **actually** pays, your responsibility may be more or less than what was quoted. If your insurance does not cover costs as estimated, the remaining portion will become your responsibility.

Please realize that dental insurance policies restrict payment for some services, and use restricted fee schedules (called usual and customary rates), and they also exclude some procedures based on prior conditions or length of time on plan. All restrictions are based on premiums paid for insurance, not our fees or recommended treatment.

If the balance is not paid within 90 days of the procedure it will be subject to collection fees and may be turned into a collection agency. The patient (or guardian) is responsible for any collection fees, as well as any court costs related to delinquent accounts.

If your insurance company sends you the insurance payment, it is your responsibility to provide the check and explanation of benefits to our office immediately for proper credit to your account. We have estimated your insurance and have not collected this portion on your account. The payment must be received in our office to prevent any reporting of wrong doing to your insurance company and/or any other company involved.

The patient (or guardian) is fully responsible for the treatment performed in this office regardless of any estimates given, or insurance payments made.

As a courtesy to our valued patients we would like to let you know that there will be a charge for copying or transferring records. Thank you for understanding that if you took full advantage of our discounts, coupons or other offers that complimentary dental x-rays and decide to transfer or have a copy of your records the charge will be $50.

Thank you for trusting us with your dental needs. Our promise to you is to strive to provide quality dental care for you and your whole family. We will answer any questions you have. Please do not hesitate to ask.

By signing below, you acknowledge that you have read, understand and agree to the patient policies of Brookside Family Dentistry and authorize our practice to release the information acquired in the course of the dental treatment to your insurance company.

Patient/Guardian Signature_____ Date_____

Patient/Guardian Name (please print) _____

Minor Patient Name (if applicable) _____