OFFICE FINANCIAL POLICY

We at **KEOWEE FAMILY DENTISTRY** are excited to have you as a patient in our office. We feel that good communication is the key to any successful relationship; therefore we would like to take the opportunity to briefly explain some of our office policies which will include the sometimes confusing issue of YOUR Financial Responsibility.

Due to having a number of patients schedule appointments and then not show, we have had to implement a policy which REQUIRES 24 hours notice of any appointments that you cannot keep. We do realize that emergencies arise which may prevent you from notifying us prior to the 24 hours. The first appointment missed or late cancelled you will receive a "waive fee" letter notifying you of that appointment. **Without 24 hour notice for the second** appointment missed we reserve the right to charge you a $50 fee for the reserved time. As you are aware, there are times in which we may have to call you to re-schedule an appointment you have scheduled with us due to our own emergencies or situations. We do respect your time also and will do everything in our power to reach you as soon as these situations arise.

Please be advised that we will make an attempt to reach you by phone at least 1 day prior to your scheduled appointment, as a courtesy reminder. Remember, this is a courtesy reminder and if we are unable to reach you at this time, this is in NO WAY an excuse for you missing your appointment. At the end of your appointment or at check-out you should be given an appointment card if there is a need for you to return for restorations and/or your next cleaning with the hygienist. If you do not receive an appointment card at this time, please let us know before you leave the office.

UNINSURED PATIENTS

IF YOU DO NOT HAVE INSURANCE YOU MUST PAY IN FULL TODAY. Unfortunately, we do not offer an in-house payment plan. We do have a program you may apply for called CareCredit. You must fill out an application. We can call this in or you may apply online. If you are interested in this option please feel free to ask and we will be glad to share the information with you.

INSURED PATIENTS

Please keep in mind that your insurance is a contract between you and your insurance company and that **YOU** are ultimately responsible for any treatment that you have completed. As a courtesy to you, we will prepare all the required forms and will file them for you. YOU ARE RESPONSIBLE FOR YOUR ESTIMATED portion at time of service. Please be advised that the amount you are asked to pay at time of check-out may not be the total amount due this office. We do not know the amount your insurance is going to pay until we receive the payment. The amount you are being asked to pay is the percentages that we are told by your insurance company that will be your portion. These percentages are based on our charges not their ALLOWABLE CHARGES. (Currently these charges are very close in comparison) If your insurance does not pay the amount we have estimated then you will receive a statement for the balance which is due upon receipt. If your insurance pays over the amount estimated then you will have a credit on your account for future treatment or you may request a refund of the overpayment.

****Please be advised that your employer may tell you that you will receive "TWO FREE CLEANINGS PER YEAR" and this is not necessarily correct. Most insurance companies pay 100% on Preventative Care.****

What they don't explain is the fact that it pays 100% of THEIR ALLOWABLE FEE.

For example: say we charge		your insurance allowable
$50.00	prophy/cleaning	$48.00
$50.00	x-rays	$45.00
$100.00		$93.00

You will be responsible for the $7.00 difference if you have an insurance that we are not in network with; therefore it is not free. This is just an example; please ask if you have ANY questions concerning this.

It is our desire to make every effort to inform you of your estimated cost prior to the date that services are rendered. However, hard as we try, this sometimes may not occur. Please make sure that you are aware of and understand what your financial responsibility will be prior to the date that services are to be rendered.

**We will gladly file to your secondary insurance also; keeping in mind if we are aware that your secondary is not going to pay we will inform you of that and we will not file to them for specific procedures.

**Please be advised that you are responsible for all monies not paid by your insurance company within 45 days of filing your claim.

**You will receive a monthly statement showing any outstanding balance. Any balance carried over 30 days will receive a finance charge of 1.5% or $1.00 whichever is greater. If the amount you owe exceeds 90 days past due, your account will be considered delinquent and further collection measures will occur. Please be advised that any/all phone numbers, including but not limited to cell phones, will be used should such occasion arise.

**If you have any questions concerning the above information, PLEASE ASK PRIOR TO SIGNING BELOW. Thank you and we look forward to giving you the excellent care that you expect.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO ABIDE BY THESE POLICIES.

_____ _____

Print Patient/Guardian Name Patient/Guardian Signature

_____ _____

KFD Staff/Witness Date

**I authorize release of information to my insurance company upon each visit and that payment is made directly to KEOWEE FAMILY DENTISTRY. My authorization also applies to my dependents. **