

ALBINA VEYS, D.M.D. - FINANCIAL POLICY

In order to maintain dental service for our patients, it is necessary that you understand our credit and collection policies. Your insurance policy is an agreement between you and your insurance company. In contrast, an agreement on services is an agreement between you and your doctor. When you have services performed, you become responsible for payment of the doctor's fees. Coverage for services and levels of payment by your insurance company depend on the terms of contract between you and your insurance company. You are responsible for any amount not covered by your plan. Most insurance plans indicate a maximum yearly amount, usually \$1,000 or \$1,500 per year for dental services. It is the patient's responsibility to be aware of this maximum and to pay any amount which exceeds the maximum.

Verification of Benefits: It is your responsibility to provide us with your current insurance coverage. Please familiarize yourself with your coverage and that it is active at the time of your dental services.

Deductibles: This is the total amount of covered dental expenses that must be paid by the patient before the insurance company begins paying benefits. Examples of standard deductibles are \$25 or \$50 per person and/or family each calendar year. You are responsible to pay the deductible.

Co-Payment: This reflects a defined share of covered dental costs that the patient pays with the insurance carrier paying an amount based on the patient's policy. Co-pays are due at your appointment.

Reasonable and Customary: This is what your individual insurance carrier has established as their payment schedule for services. Each insurance carrier sets their own reasonable and customary fee schedule and this varies from one insurance carrier to another. Therefore, we are unable to determine what reasonable and customary is because there is not one set schedule that the insurance companies base their reimbursement on.

Past Due Balances and Collections Accounts: If you have a past-due balance, you will be required to make payment on this prior to being seen. You will be responsible for 30% Collection fee on past due balances.

Pre-determinations: This is an ESTIMATE of payment and co-payment and not a guarantee of payment. If Insurance carrier does not pay for any reason, it is your responsibility to pay for services rendered. As a courtesy this office will submit predeterminations for crowns, removable or fixed prosthetics, and implant supported restorations. The following methods of payment are welcome: Cash, Personal check, Visa, Mastercard and Care credit.

Signature of Patient/Guardian: _____ Date: _____