# Financial Responsibility Policy

For all patients it is necessary to have an easily understood financial responsibility policy whether or not you have dental insurance. If you have dental insurance, we will assist you with your insurance as outlined in this policy. All patients/responsible parties must sign this form prior to seeing the doctor.

- It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. At each office visit we need you to provide us with any changes in insurance information or contact information.

- As a service to our patients, we will submit your insurance claim to your primary insurance company with all the information necessary to help maximize your benefits. If the patient has coverage with a second insurance company, we will submit all secondary claims directly to that insurance company along with a copy of the explanation of benefits from the primary insurance. Coordination of benefits is inherently unpredictable. It is the patients' responsibility to know the insurance coverage and benefits limit (plan year maximum insurance will pay) of their particular policy.

- North Rockville Dental is not responsible for whether or not a service performed is a covered benefit. If a claim is denied, we will appeal and resubmit to insurance on your behalf or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance becomes the responsibility of the patient. You may contact your insurance company or human resources department for further appeal. Any balance is your responsibility whether or not your insurance company pays any portion.

- At the time of service, the office will estimate the anticipated insurance payment and will collect the estimated balance due along with any deductible. We cannot guarantee any estimates. After the primary insurance payment is received any related adjustments will be performed and the patient will be billed for any balance due. If the insurance payment is greater than was anticipated, we will either refund the amount to the patient or credit the account for future treatment.

- In the event that the patient does not have insurance coverage or the patient's insurance company sends the insurance payment directly to them, charges for services are due and payable in full at the time services are rendered, unless financial arrangements have been made.

- In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We realize unforeseen events can occur and ask that you to please help us serve you better by keeping scheduled appointments or providing notice of cancellation 24 hours in advance.

Insurance benefits are estimates only. I understand that I am responsible for co-payments and deductibles, along with any procedures that my insurance company does not cover. I am also responsible for any balance due because of insurance claims not paid within 60 days of service. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. North Rockville Dental reserves the right to charge a monthly billing fee and to use a Collection Agency for the collection of an account and will charge that account any collection fees involved. I have read and understand the above and I agree to be responsible for payment of all services rendered and any billing/collection fees accumulated on my behalf or that of my dependents.

**I have read, understand and agree to the terms and conditions of this Financial Agreement.**

**First Name:**_____ **Last Name:**_____ **DOB:**_____

**Signature:**_____ **Date:**_____