

Office Financial Policy – Updated 10-17-2016

Dear Families,

In the interest of good healthcare practice, it is desirable to establish a financial policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good oral health and we wish to spend our time and energy toward that goal.

Our policy is to make your experience an exceptional one. You can expect the utmost professionalism and courteousness from myself and my staff. In order for this office to provide you with the highest quality of dental care and most effective services as possible, the following policies must be agreed upon:

1 – **Insurance.** Insurance(s) are gladly billed as a courtesy to our patients when current card(s) are provided to us. Insurance reimbursement is a contract between you, your employer and your insurance carrier. YOU are responsible for payment of your account. You are responsible to be aware of your benefits, changes to your benefits and to contact your carrier directly when issues arise regarding timely payment of claims or denials. We cannot accept responsibility for follow-up on your claims, negotiating a disrupted claim, change of insurance fees, or claim denials. Our staff will assist you, if appropriate or as needed.

2 – **Insurance Payment.** If insurance payment is not received within 60 days of submission of the claim, you will be informed of your responsibility to contact the insurance company and ensure that payment in full is received promptly. It is your responsibility, not the office, whether your insurance company pays on time.

3 – **Co-Pays/Deductibles.** All copays and/or deductibles are due at the time of service. Our office makes the best attempt to estimate your responsibility prior to treatment, however we are not responsible for how your insurance ultimately pays. Our office accepts Visa, MasterCard, American Express, Discover, Cash, Checks and Care Credit.

4 – **Cancellations and No Shows.** We make it our responsibility to contact you by phone, email or text at least 24 hours prior to your appointment to confirm. Office policy requires a 2 business day cancellation request on your part. If you fail to show for your appointment with no notice given you will be charged a \$50 breach of policy fee. The office, at its sole right and discretion, may suggest to any patient guilty of these habits, find another dental professional.

5 – **Zero Balance Ledger.** We run a zero balance office, which means all outstanding accounts are due and payable at the time of your visit, unless satisfactory arrangements have been previously authorized. Any anticipated patient responsibility after insurance is due and payable at the time of service. We will only balance bill a portion which was either changed by an actual insurance payment wherein we could not appropriately estimate the patient responsibility upfront. Any reimbursements due to a patient will be processed immediately as well. There is a \$30 late charge if balances are not paid at the first billing attempt and subsequently \$30 each month thereafter. All accounts past due more than 60 days will be subject to collections. A collection fee of 50% of the total balance, including late charges is also applied.

6- X-ray or Form Completion. Copies of x-rays are released for a charge of \$50. Please note that the fee charged and accepted for the initial x-rays taken is for the chair time, materials, administration, evaluation and professional fees.

7 – Returned Checks. A \$35 charge will be added to accounts for each check that is not honored by your bank. If two checks are bounced, we reserve the right to require an alternate method of payment, either cash, money order or credit/debit in the future.

8 – Family Accounts. Please note that any adult within the family unit is responsible for the entire account. For example, a wife is responsible for the balances owed by the husband, civil partner and/or children/dependents, and a husband is responsible for the balances owed by wife/civil partner and/or children/dependents.

We believe these policies are necessary and fair to afford you a comfortable and reliable practice wherein you can be confident your dental needs and oral health will be taken care of which in turn aids in your overall health and wellness.

Sincerely,

Dr. Jared Berger and Staff

Any changes to this policy will be made at the discretion of Family Dentistry of Brick, P.A., and will be dated and posted in a common area of the office and available in print upon request.

I, _____, have read, understand and agree to the Office Financial Policy updated 10-17-2016. If you would like a physical copy of the Financial Policy please initial. _____

Printed Name

Signature

Date

Witness

Date

FAMILY DENTISTRY OF BRICK, P.A

DR. JARED BEGER

35 BEAVERSON BLVD. SUITE 3B

BRICK, NJ 08723

732-920-7700

EMAIL: DRJARDBERGER@YAHOO.COM