

Millwood Family & Cosmetic Dentistry

744 Arden Lane, Suite 150 Rock Hill, SC 29732

Phone: (803) 980-7645

Patient Financial Policy

- **Patient's Payment** - Patient's payment for services to be provided is due at the time of service. We gladly accept reimbursement for services from insurance companies. However, the patient's portion of payment due at the time of service will be estimated pursuant to information provided from the patient's primary insurance company. Please note that many insurance companies will pay for services based on their independent calculation of fees, not our established fee schedule, which may increase the patient's portion due at the time of service. If the patient's insurance company does not pay the practice within a reasonable length of time (typically 3 weeks), if payment is less than our established fees, or if services are denied, the patient is responsible for the full remaining balance for services provided and such payment is due upon receipt of an explanation of benefits from patient's insurance company or a statement from our office, whichever is earlier. If there is a credit balance on a patient account, it will be applied to scheduled future services or refunded to the patient during the next billing cycle.
- **Payment Methods** - For your convenience, we accept cash, checks, Visa, MasterCard, and certain terms of the Care Credit program. In the event a check is returned to us for insufficient funds, we will apply a \$25 returned check fee to your account. This amount, in addition to your original account balance will be due effective immediately.
- **Delinquent Accounts** – A patient will be delinquent on an account if the patient's billed amount is not received by the first billed due date or if a patient fails to pay their estimated portion at the time of service. Patients with a history of a delinquent account will be required to pay by cash or credit/debit card any delinquent amount on the account and the established rates for all services to be provided prior to receiving such services. If a patient has insurance, we will file the insurance and reimburse the patient any credits on the account at the end of the month after the disposition of the claim.
- **Financial Responsibility for Minors** - For all minor patients, we will consider the adult accompanying the patient as the parent or guardian and, therefore, responsible for payment at the time services are rendered.
- **Cancelled and Broken Appointments** - As a courtesy, we will attempt to contact you a few days prior to your scheduled appointment as a reminder. We ask that you please call us 48 hours in advance if you need to cancel and/or reschedule, so that another patient who is in need of our services can be seen. In the event of a broken appointment without 48 hours notice, we reserve the right to charge a cancellation fee of \$25.00. Furthermore, you may be required to leave a deposit of \$50.00 to secure future appointments. The \$50.00 deposit will be applied towards your treatment if the appointment is kept. If the appointment is cancelled or broken without proper notification, the \$50.00 deposit is forfeited.

Please feel free to discuss any suggestions or concerns you may have with our Office Manager at any time. Complete understanding of your financial responsibilities is an essential element of your care and treatment.

Dental Benefit/Insurance Policy

As a courtesy to our patients, we will file your dental benefits claims and accept payment or partial payment directly from the benefit providers. In estimating the patient's payment for services, we will obtain a brief description of dental benefits from your provider.

Although we are available for guidance, it is ultimately the patient's sole responsibility to know, understand and comply with all the terms and conditions of their dental benefits policy, including but not limited to, the benefit year, the benefit year maximum, deductibles, coinsurance percentages, fee schedules, missing tooth clauses, waiting periods, frequency and age limitations, replacement clauses, exclusions and/or substitutions of services. Please contact your benefits carrier with questions regarding your specific plan if you have any concerns.

Our office will make a concentrated effort to collect payment from benefit providers and will provide the necessary information requested from them to process your claims. However, if claims are denied for any reason, the balance of the payment for services is the patient's financial responsibility.

I have read and understand the **Financial Policy** and **Dental Benefit/Insurance Policy** of Millwood Family & Cosmetic Dentistry and agree to be bound by its terms.

Patient Signature Form

I have read and understand the **Financial Policy** and the **Dental Benefit/Insurance Policy** of Millwood Family & Cosmetic Dentistry and agree to be bound by its terms.

Print Name Signature and Date

Do we have permission to contact you via email?

Yes No Email: _____

Do we have permission to contact you via text message?

Yes No Phone Number: _____