# Dr. Eric C. Felt, D.D.S.

Financial and Office Policies

Welcome! Thank you for selecting Dr. Felt as your dental health care provider. Our goal is to provide you and your family with optimal dental care at the best price. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy. Please read and fill out both sides of this agreement (if applicable).

Patients are expected to pay for our services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, American Express, Mastercard and/or Discover. We also offer CARECREDIT which is a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance charge of 21% per annum (yearly) after 90 days.

Emergency patients, new to our practice, should expect to make a payment at the time of service.

**Insurance Information:**

As a courtesy to our insured patients, we submit claims to your insurance company, in your behalf, free of charge. We will help you to receive your maximum allowable benefits. In order to do this, we need your insurance card and/or insurance policy with you on your first visit of every calendar year. Most insurances require co-pays with preventative, basic, and major services. Co-payments are due at the time of service. As a courtesy we can estimate the amounts, but actual co-payments are by your insurance company after your claim is submitted. You agree to pay the remainder of co-payments within 90 days, and are determined by your insurance company after your appointment. You also agree that not all dental services are guaranteed covered benefits under insurance.

If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office. You will receive any insurance benefit paid for that service thereafter directly. We will try to help you with lingering claims, but we cannot be held responsible when your insurance company won't pay a given claim. The insured together with their employer is better able to work with the insurance company.

**Appointments:**

We require at least 24-hour notice for any cancelled appointment. We reserve the right to charge and collect $50 for missed ("no-show") appointments.

**Collections:**

We send out billing statements monthly as a courtesy for patients to know their total balance. Unless prior arrangements with monthly checks or an automatic credit/debit card payments are made, a delinquent account over 90 days will be turned over to collections. Should your account be turned over to collections, the undersigned agrees to pay all costs to collect the debt including, but not limited to, interest in the amount of 21% per annum, attorney's fees, court costs, and collection fees in the amount of 40%. The obligation to pay the collection fees shall be imposed at the time of assignment of the debt to a third party collection agency.

# Dr. Eric C. Felt, D.D.S.

Financial and Office Policies

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of yourself and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children and/or spouse who are patients of the practice.

**HIPPA Information Release: Authorization for Use of Disclosure of Personal Health Information**

I authorize all staff at Eric C. Felt, D.D.S. to use and disclose my protected health information to the appropriate insurance carriers, law enforcement agents, and head of households as indicated and appropriate by law. This authorization covers all past, present, and future periods unless invoked in writing.

I understand that I am responsible to pay for any deductible amount(s), my co-pay portion, and for any non-covered services. I understand that I am financially responsible for any and all charges for dental treatment and incurred fees, whether or not they are paid by said insurance policy which I hold. I agree to pay such charges in full. I also hereby authorize the release of pertinent medical and dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

I hereby authorize the release of pertinent medical and dental information to the insurance carrier(s) for the use of filing claims and checking on claim status. This order will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

I agree to all of the policies and practices on both sides of this document

_____ _____

Patient Name Date

_____

Patient Signature, or Legal Guardian, if patient is a minor