FINANCIAL POLICY

Mason Dental Associates

Patient Name: _____ Date of Birth: _____

Responsible Party: _____ **(Signature Required)**

____ I. Our objective is to provide you with the highest quality dental care in the most cost-effective manner. However, the ability to achieve this depends on your understanding of our financial policy and of your financial responsibilities. If you have dental insurance, we will file a claim on your behalf. We do this as a courtesy to our patients.

____ II. *FAILURE TO KEEP APPOINTMENTS AND SHORT-TERM CANCELLATIONS/RESCHEDULES = $50.00 CHARGE.*

There is a $50.00 charge to patients who **DO NOT SHOW** for their appointments or who cancel or reschedule within 24 hours of their appointment time. Those that don't keep an appointment delay the delivery of dental care to other patients. We appreciate your cooperation in striving to keep every scheduled appointment. Three(3) NO SHOWS is grounds for DISMISSAL.

____ III. *PATIENTS WITH **NO INSURANCE***:

Patients with no insurance are required to pay in full at the time of service. We accept cash, check, Visa, MasterCard, AMEX, Discover and debit cards. Care-Credit for qualified applicants may be used; however, you must ask receptionist about this **NOW**, prior to service being rendered. If you need assistance with financial arrangements, please speak with our insurance specialist prior to appointment.

____ IV. *PATIENTS WITH WORK-BASED (EMPLOYER) PROVIDED*:

The only sure way to know what your insurance will pay is to obtain a "pre-determination" of benefits in writing from our insurance company. This process may take 2-3 weeks and requires x-rays to be sent to your insurance company. When we receive your pre-determination you will be contacted and notified of the portion you are required to pay. In the event you wish to proceed with dental treatment prior to obtaining a pre-determination, you will then be required to pay for the treatment **IN FULL** at the time of service. We highly recommend any charges that exceed $300.00 be approved by your insurance company. Pre-determination is **NOT** a guarantee of payment. Patient is responsible for all charges **NOT** covered by insurance.

____ V. *PATIENTS WITH HMO INSURANCE*:

This office is **NOT** an HMO contractor.

____ VI. *PATIENTS WITH PPO INSURANCE*:

This office is **NOT** a PPO provider; however, some PPO plans allow you to go to a dentist of your own choosing, but some require you only see one of their contract dentists. Please check your policy restrictions.

____ VII. *MEDICAL / PEACHCARE / DENTAQUEST / DENT A TRUST*:

This office is NOT a provider.

____ VIII. *MEDICARE DENTAL SUPPLEMENT*:

We have found these plans to be practically worthless. You are required to pay the cost of your dental treatment. If you are lucky enough to receive any payment we will gladly reimburse you. One exception is that flat rate benefits plans which will pay a certain allotted amount with no deductible and no co-pay. Inquire with our insurance coordinator.

____ IX. *PATIENTS WITH DOUBLE COVERAGE*:

We can only pre-determine your primary coverage benefit. Some companies use the term "benefit-less-benefit", which is one way the second carrier can refuse payment. We still gladly file your second carrier.

____ X. *DELTA DENTAL (HEADQUARTERS LOCATED OUT OF GEORGIA)*:

All payments are sent directly to you. ***Patient is responsible for ALL charges EACH time of service. NO EXCEPTIONS!***

____ XI. *DELTA DENTAL (IN STATE - GEORGIA)*:

Treated same as Section IV (work-based provided insurance).

____ XII. *DIVORCED PARENTS (MINOR CHILD(REN)*:

The parent providing the insurance and the custodial parent (if applicable) MUST sign as guarantors in the order to obtain dental care. We require this to prevent any misunderstanding between ALL Parties. In the event the court-ordered guarantor cannot be present, the parent bringing the child to the office must sign as guarantor.

____ **I understand the financial requirement described above and agree to abide by these requirements. In the event that I fail to pay this account, I agree to pay any and all collection costs up and including collection agency and attorney fees.**

My Method of Payment is: Cash ___ MasterCard ___ Visa ___ Discover ___
AMEX ___ Debit/Credit ___

I AUTHORIZE Mason Dental Associates to Process Charges to My Credit (Debit) Card.

Acct. No. _____
Exp. Date: _____
Security Code: _____
Zip Code: _____

SIGNATURE: _____ **DATE:** _____