# HIGHLAND FAMILY DENTAL

## PATIENT CONTRACT AND FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are dedicated to providing excellent dental care for you and your family. The following is a statement of our financial policy, which we require you to read and sign prior to treatment the first dental visit of each calendar year.

## PATIENT OBLIGATION IS DUE IN FULL AT THE TIME OF SERVICE

Due to the high cost of technology, equipment, dental supplies, sterilization and general overhead expenses, we are forced to be very firm on our payment policy. As a courtesy to you we bill your insurance. Any co-pays or coinsurance amounts are required at the time of service. Because we are not a financial institution, we have set up payment contracts with CareCredit that can provide you with no interest, no finance charge options. We also accept most credit cards. Often insurance companies can take months to pay on a claim. By not carrying patient balances, we are able to keep our fees reasonable.

## REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some services we provide may not be covered services and may not be considered as necessary under you particular dental plan. We will, upon request, process a pre-determination of your treatment plan with your insurance prior to dental care. This will provide their decision on treatment coverage so there are no financial surprises. Although we do our best to know the details of your policy, YOU are ultimately responsible for knowing your policy including but not limited to maximum benefits, deductibles, exam limitations, general frequencies and dollar limit figures. Our practice is committed to providing the best treatment for patients and our fee schedule is considered *usual and customary* by most insurance companies. You are responsible for payment regardless of any insurance company's arbitrary determination of what they consider *usual and customary.*

You are considered a cash patient until you provide the necessary insurance information, which includes insurance carrier name, subscriber's legal name, birth date, SSN or ID#, group # and contact phone, so that we may verify coverage, benefits and billing address.

## MISSED APPOINTMENTS

We reserve an appropriate amount of time for your dental appointment. As we will always do our best to respect your time, we ask that you respect ours by arriving on time. When your appointment is missed or cancelled with less than 48 hours advance notice a $65 missed/broken appointment fee will be charged. As a courtesy we do waive this missed appointment fee ONE TIME.

I have read and fully understand the terms and conditions of this contract. My signature below is to be considered assignment of insurance benefits directly to Dr. Cho. I agree that I am solely responsible for all bills incurred for treatment received on myself and/or any dependents I am responsible for. Dr Cho is not responsible for unpaid insurance claims or denials. Dr Cho does not promise or guarantee that my insurance will pay any claim.

Printed Name of Responsible Party: _____

Signature: _____ Date: _____