



OUR FINANCIAL POLICY

Welcome

We, the staff of Smileville Family Dental Center thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact Smileville Family Dental Center at (813) 994-4777

We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance or participate in a plan that will not honor an assignment of insurance benefits, payment for services will be due at the time of service. We make payment as convenient as possible by accepting (cash, money order, MasterCard, Visa and in-state checks).

Balances and Fees

Please understand that statements will be sent regarding any overdue balances and we will inform you of these balances. Effective January 1, 2015 our office will be charging a fee for any outstanding balances. Any fees past due by 30 days from the date of service will incur a \$10.00 charge. Any balances over 60 days from the date of service will accrue a \$20.00 charge. Any balances that are past 90 days from the date of service will obtain a fee of 20% of balance or \$40.00 whichever fee is greater. A \$35.00 service fee will be charged for all returned checks. Additionally, you may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security. _____ (Please Initial)

Insurance

Please understand that the staff at Smileville Family Dental Center do our absolute best to ensure you are eligible for services that are being performed and should your insurance carrier deem services ineligible Smileville Family Dental Center is legally obligated to collect all patient portions. Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims. It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. **It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan.** Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, co-insurance and deductibles, as outlined by your insurance carrier and will be done so prior to the treatment. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of network fees. If we are not contracted with, your carrier we will not negotiate reduced fees with your carrier. _____ (Please Initial)

Missed Appointments

We require notice of cancellations **24 hours in advance**. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically \$35.00 but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients. _____ (Please Initial)

MORE ON REVERSE SIDE



Medical Records Fees

Patients are entitled under federal law to have access to their protected health information and we follow all rules, guidelines and exceptions to ensure compliance to patient rights. However, providers also have the right to compensation for records and our fees are a reasonable cost-based fee for copies including the copying, supplies, labor and postage of the files and or summaries. We realize that temporary financial problems may affect timely payment of your account. If this should occur, please contact us for assistance in the management of your account. Our goal is to provide quality care and service. Please let us know immediately if you require any assistance or clarification from anyone within our business. Should you require copies or duplicates of records there will be a \$20.00 fee. _____ (Please Initial)

Timeliness of Appointments

We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule you if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits to whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary. _____ (Please Initial)

Lab Fees/Upgrades and Uncovered Benefits

Should you make a personal decision to obtain a better quality crown than your insurance carrier pays for you are responsible for all fees associated with this upgrade and will be noted and discussed on your treatment plan prior to treatment. Under Florida Law we are to charge you our Usual and Customary Fees for any services that are not covered by your insurance policy. Most insurance plans will cover only silver fillings. While our office does offer this option many of our patients would prefer a tooth colored filling. We are happy to provide this option, but there is an upgrade fee for the service uncovered by insurance. These fees are the patient's responsibility. If your insurance should send you a check for services rendered in error you have 48 hours to forward to our office _____ (Please Initial).

Signature of Insured or Authorized Representative: _____ Date: _____