Back Mountain Dental Financial Policy

Our primary mission at Back Mountain Dental is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. To assist you with your dental care investment, we provide the following payment options:

1. **Cash**- includes money orders and personal checks
2. **Credit Card**- Visa/MasterCard, Discover & American Express
3. **CareCredit®-** patient payment plans that allow you to pay overtime with convenient low minimum monthly payments. With CareCredit, you enjoy these benefits: *
    a. Flexible financing options
    b. No annual fees or prepayment penalties
    c. Quick and easy application
    d. Receive a credit decision almost immediately
    e. Start your recommended treatment immediately*
4. **Dental Insurance**: Understanding your insurance coverage can be quite a challenge. Our goal is to provide reasonable assistance to help you maximize your benefits. Many dental insurance plans exclude coverage for some services, uses restricted fee schedules for most services, and can decline payment based on any number of policy restrictions and limitations. All such restrictions and limitations are based on your contract with your insurance carrier, not on our fees or the treatment we recommend. We encourage you to become familiar with your policy: its coverage, exclusions, deductibles and maximums. *We will recommend treatment appropriate to your dental needs regardless of your insurance status.* ***(initials)*** _____

Our courtesy service to our insured patients includes:

- Filing your claims promptly and requesting that payment be sent directly to us.
- Following American Dental Association guidelines for claims coding and filing.
- Estimating your benefits to the best of our ability. Most insurance companies will not provide us with detailed information about your coverage, so any insurance copays we provide you are only estimates! ***(initials)*** _____

Our expectations of you as the insured patient and/or owner of the policy:

- You will pay, at the time of treatment, all fees not estimated to be covered by your insurance. ***(initials)*** _____
- You will assume responsibility for any amounts expected from your insurance company but not received within 60 days after treatment has been performed and the claim submitted. Please understand that the insurance policy belongs to you & we have NO leverage to obtain payment from your insurance company. ***(initials)*** _____
- Realize that dental insurance policies restrict payment for some services, use restricted fee schedules (called UCR) and exclude some procedures bases on prior conditions or length of time on the plan. All restrictions are based on the premium paid for the insurance, not our fees or recommended treatment. ***(initials)*** _____
- For your convenience and to keep our costs down for you we ask that you leave a credit card on file that we can charge if there are any monies owed after your insurance claims are paid ***(initials)*** _____
- I will take responsibility for any fees my insurance does not cover after 60 days. We ask that you pay the balance after receiving your first statement from us. ***(initials)*** _____
- I understand that interest charges of 1.5% per month will accrue on balances older than 30 days and a rebilling charge of $35.00 will be added to subsequent statements and your account will be turned over to a 3rd party collection agency and/or the magistrate after 90 days. ***(initials)*** _____

Our expectations of you as a patient of Back Mountain Dental:

- Payment in full is due at the time services are rendered, unless other payment arrangements have been made prior to your appointment. ***(initials)*** _____
- Should you need to change/cancel your appointment; changes require a **48** hour notice (M-Th 9-5pm) in advance otherwise a no show fee of $25 will be imposed. By giving us adequate notice, we may be able to give another patient the courtesy of a sooner appointment. We make every effort to remind patients of their appointment at least two days in advance. This is done as a **courtesy only**. Patients are ultimately responsible for remembering to keep their appointments. ***(initials)*** _____

I hereby authorize Back Mountain Dental to release to my insurance company any information acquired in the course of my dental care. I authorize benefits to be paid directly to Back Mountain Dental. I understand I am responsible for **all fees** incurred, regardless of the status of insurance; payment is **due in full** at the time services are rendered.

Responsible Party

Signature _____ Date _____

Back Mountain Dental, Inc.

210 Carverton Rd.
Trucksville, PA 18708

Phone: (570) 696-1105

Dear Patient:

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT
We now offer the following payment options:

___ Payment by cash

___ Payment by check

___ Payment by credit card

___ Guarantee any amount not covered by insurance with Visa or MasterCard.

Please make your choice, sign below and return to office manager before treatment.

Our office is a fully approved and accredited user of the *Visa and MasterCard Health Care Program* which will enable you to use your Visa and MasterCard to automatically cover amounts not paid by your insurance.

If none of the above apply, please see the office manager. Thank you.

_____
Print your name here and sign below

*x*_____
*Date:*_____