SOUTH RIDING ORAL & IMPLANT SURGERY

FINANCIAL AGREEMENT

Our staff is sensitive to the financial aspects of healthcare and we constantly strive to control those costs. We know that this is delicate for many patients and want you to feel free to discuss any concerns that you may have at any time. We have formulated our financial policies to try to make your experience as positive as possible.

There are many insurance companies that offer dental insurance. Their plans can be complex, and may include deductibles, co-payments, co-insurance and even exclusions of coverage for certain procedures. We will make every effort to maximize your insurance benefits.

IF YOU ARE COVERED BY INSURANCE:

- You are responsible for knowing the terms and the exclusions of your policy.
- To maximize your benefits, it is essential that you provide our office with accurate and complete billing information before services are rendered. If this is not achieved, we will treat it as though no coverage exists and our policies for non-insured patients will apply.
- We are happy to send a pre-authorization to your insurance company to determine estimated benefits and strongly suggest doing so. This is not, however, a guarantee of what your insurance company will cover and it can take up to several weeks to receive this information from your insurance company. Not all circumstances allow the time necessary to accomplish this.
- Often, people are under the impression that if a person has insurance, it is the insurance company who owes the doctor for services rendered. The insurance contract, however, is between the patient and the insurance company only. Therefore, the patient (of the guarantor) is ultimately responsible for the bill, regardless of insurance coverage determination (or pre-determination). All treatment fees are due within 60 days, regardless of insurance payment.

IF YOU ARE A CURRENT MEMBER OF ANY OF THE PLANS TO WHICH WE SUBSCRIBE:

- Our charges will not exceed the amounts permitted under your plan for covered services.
- We will make a concerted effort to verify your coverage.
- If circumstances, over which we have no control, prevent verification of your benefits, we will require a 50% deposit at the time that the services are rendered. We will promptly bill your carrier for the services and will reimburse you for any overpayments upon payment from you plan. *Your signature at the bottom of this for acknowledges that you have read and agree to the terms just mentioned.*
- In the event you are not a member of the plan, or your plan does not cover the services you receive, you will be directly responsible for the payment of our fees.

IF YOU ARE A MEMBER OF AN INSURANCE PLAN TO WHICH WE DO NOT SUBSCRIBE:

- All charges incurred at an examination appointment are due in full at the time.
- We require a deposit at the time of your surgical appointment. This deposit is typically 50% of the total charge but is based on our insurance claims experience and knowledge and may fluctuate due to the circumstances involved.
- We will bill your insurance company as a courtesy to you. It is our goal to maximize insurance benefits in order to keep your out-of-pocket costs toa minimum.
- Pre-authorizations are highly recommended but are only done at the patient's request.

IF YOU ARE NOT COVERED BY INSURANCE:

Patients without insurance coverage are expected to make payment in full for all charges at the time of service. Please see "Payment Options" for more information on forms of payment accepted.

MEDICARE BENEFICIARIES:

Dr. Raja does not participate in Medicare and cannot bill Medicare for any services that he provides for Medicare eligible patients. We welcome Medicare patients, however, all charges are payable by the patient.

☐ **PLEASE CHECK BOX IF YOU ARE ELIGIBLE FOR MEDICARE**

IMPLANT SURGERY:

Implant surgery may not be covered by your insurance plan. If you wish, we will contact your insurance company to get a written pre-determination of benefits on your behalf. If a pre-determination, showing implant coverage, is received by our office prior to your surgery, the amount of your deposit will be based on this pre-determination. Our financial coordinator will finalize the financial details with you prior to surgery. Please know that it is important to us that you fee comfortable asking any questions that you have. Please do not hesitate to do so.

PAYMENT OPTIONS:

WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, DEBIT CARDS, CASH, PERSONAL CHECKS OR CARE CREDIT. You may inquire about Care Credit @ www.carecredit.com or call (800) 859-9975.

Please note: We require a social security number or a copy of your driver's license for any fees not paid in full by cash.

STATEMENTS:

If you have a balance on your account, we will send you a statement. This balance is due in full upon receipt of your statement.

MISSED APPOINTMENTS:

Although we understand that occasionally circumstances arise that make it necessary to cancel or reschedule appointments, we reserve the right to charge for missed appointments. If an appointment for surgery is canceled without giving one business day's notice, payment in full will be required before an appointment will be scheduled.

INTEREST:

We reserve the right to charge interest at the rate of 1.5% per month or 18% per annum on balances unpaid after 120 days.

PAST DUE ACCOUNTS:

If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency or credit bureau, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer or we pursue collections thru small claims court, you agree to pay all lawyers' fees plus any and all court cost which we incur. In case of suit, you agree the venue shall be Loudoun County, Virginia.

There will be a $30.00 service charge on any check returned unpaid by your bank.

AUTHORIZATION:

With my signature below, I hearby authorize release of any relevant information necessary to process my claim to my insurance company. I also authorize any insurance benefits otherwise payable to me to be paid directly to South Riding Oral & Implant Surgery providing the services.

ACKNOWLEDGEMENT:

I acknowledge that I have read the above, understand it, and agree to the terms of this contract.

_____ _____ _____

Signature of Patient or Responsible Party Relationship to Patient Date

_____

Name of Patient (please print)

A facsimile transmission, and/or an electronic scanned transmission, shall constitute an original October 2020