Financial Policy

Thank you for choosing Kaufman & Kaufman Smile Design Studio, LLC as your Dental Care Provider we are committed to your treatment being successful. Please understand, as a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment .The following is a statement of our Financial Policy which we require you to read, initial and sign prior to treatment.

All patients must complete the patient information form at the time of visit. It is essential for you to supply us with your complete insurance information, including a claim submission address. We will scan and /or photocopy your insurance card for our records. Your signature is required at the bottom of this form to authorize: 1) the release of information for claim submission. 2) To authorize insurance benefits to be paid directly to Kaufman & Kaufman Smile Design Studio, LLC.

Office Visits: patient portion, deductibles, non-covered services and co-pays are due and expected at the time of service. If the patient DOES NOT have insurance, payment is required in full at the time of service, unless previous financial arrangements are made. We accept Cash, Checks, American Express, MasterCard, Visa and Discover. Our Financial Coordinator can assist in obtaining third party credit thru Care Credit and Lending Club. There will be a $100.00 fee for all returned checks. Balances greater than ninety (90) days past due will be assessed a $5.00 billing fee each month._____ (*please initial)*

***Assignment of Insurance Benefits/Payment Guarantor/Collection Fee*: As a *courtesy* to our patients we will submit to your primary/secondary insurance companies providing you assign benefits to Kaufman & Kaufman Smile Design Studio, LLC. We cannot bill your insurance without an insurance card and all pertaining insurance information at the time of visit. The office will gladly work with you to help get the maximum benefits available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be expected to pay your deductible, co-payment, on-covered services and your ESTIMATED patient portion the day services are rendered. Many variables exist from carrier to carrier; therefore, we cannot guarantee any estimated charges. Because your insurance is an agreement between you and the insurance company, ultimately you are responsible for all charges. If Kaufman & Kaufman Smile Design Studio, LLC is an In-Network provider *(In-Network Provider status is subject to change.)* the fee may be discounted according to a fee schedule determined by your insurance carrier. If Kaufman & Kaufman Smile Design Studio, LLC is an OUT OF NETWORK provider you will be billed at our Fee for Service and responsible for any amount due. Our Insurance Coordinator will work with you to provide the insurance carrier with adequate information regarding your claim. In some cases, treatment provided may be a non-covered service according to your plan benefits, the fee then reverts back to Kaufman & Kaufman Smile Design Studio, LLC FEE FOR SERVICE. The fee may not be considered reasonable and necessary under your dental plan; you are therefore responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. In the event YOUR insurance coverage changes to a plan where we are a non-participating provider you are responsible for all charges in excess of what your insurance company pays. YOU are responsible for advising this office of any changes in your insurance coverage prior to your appointment._____ (please initial). Accounts that are over sixty days (60) past due will not be scheduled for future appointments without bringing said account current unless financial arrangements have been approved prior by an acting Manager of the practice.**

Collection Policy*: I understand that if my account balance becomes overdue and the delinquent account is referred to a collection agency, a collection fee, not to exceed 25% of the overdue balance, may be added to the amount due. I understand I am financially responsible for the additional fee and any reasonable attorney's fee and costs incurred for collection._____ (*please initial).

Cancellation Policy*: We reserve the right to assess a $79.00 cancellation fee if the appointment is canceled less than 48 hours of the scheduled appointment time. If an appointment has been canceled numerous times without proper notification to Kaufman & Kaufman Smile Design Studio, LLC, this practice reserves the right to ask for a $150.00 deposit to hold said appointment, if that appointment is missed or not cancelled within the terms of this financial policy, deposit will be forfeited. Deposit will be credited towards services rendered and/or refunded only if patient honors the time and date scheduled. Please help us serve you better by honoring scheduled appointments._____ *(please initial)

Minor Patients Guarantor:* The Parent or Guardian accompanying the minor is responsible for full payments of treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized or approved by our above stated method of payment at the time of treatment and have been verified. An unaccompanied minor will not be treated absent the written consent of the minor's parent or Guardian..._____(*please initial)

AUTHORIZATION & RELEASE: I authorize Kaufman & Kaufman Smile Design Studio, LLC to release any information including the diagnosis and the records of treatment or examination rendered to me and/or my dependents during the period

of such dental care to third party payers and /or healthcare practitioners. I authorize and request my insurance company to pay directly to Kaufman & Kaufman Smile Design Studio, LLC. I understand that my insurance carrier may pay less than the actual fee for services rendered. I agree to be responsible for payment of all services rendered on behalf of myself and/or my dependents. I have read the conditions of treatment and payment terms and I agree to their content.

X_____**Date:**_____**Relationship to Patient:**_____
Signature of patient, parent, guarantor guardian

X_____
Name of minor

You will be provided a copy of this financial policy for your records