

New Windsor Family Dentistry
Philip M. Uffer D.D.S.
206 High Street, New Windsor, Maryland 21776
(410) 848-5260

Financial Policy

Thank you for selecting us to help take of your dental health. My staff and I are committed to your treatment being a positive experience. It is our firm belief that all people who entrust their oral health to us want and deserve the finest dental care that we are capable of providing. Please understand your financial obligations are considered part of your treatment. Our purpose in providing you this financial information is to acquaint you with our policy for our mutual benefit. We can give you an estimate of costs required in advance of treatment so that you can come prepared for each visit.

The following is a statement of our financial policy. Please read and sign before being seen.

1. All patients are required to complete our Patient History forms before seeing the doctor. Full payment is due at the time of service. Payment options include:
 - Cash
 - Checks
 - Visa, MasterCard or Discover
 - Care Credit (for amounts over \$200)

2. The following applies to those patients with dental insurance:
 - We request you provide insurance information prior to appointment so we can attain the most accurate percentages and coverage information. If at your appointment we are unable to verify your dental insurance or cannot obtain a list of benefits, full payment is due at the time services are rendered.
 - Patients are to pay their deductible and the estimated co-payments at the time treatment is rendered.
 - While filing insurance claims is a service we extend to our patients, we must emphasize that as dental providers, our relationship is with our patients – not the insurance company. In the state of Maryland, insurance companies are required to send payment within 30 days. If a full payment is not received from your insurance carrier within 60 days, the total balance becomes your responsibility.
 - Usual and Customary Rates - Our practice is committed to providing the best treatment for you at a fee that is reasonable and customary for this area. Not all companies reimburse based on a fee schedule that is current and standard for this area. Therefore, you are responsible for payment, regardless of any insurance company's arbitrary determination of usual and customary rates.
 - We will submit, as a courtesy, to secondary insurance companies when possible, however we reserve the right to stop at anytime. If we cease to file secondary dental claims, we will give you a claim form so that you can submit secondary claims to your secondary insurance carrier. Billing will not be affected by secondary insurance claim payments, i.e., you will be billed for any balance regardless of secondary insurance claim status.

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3. Overdue Balances: With the exception of true dental emergencies, appointments will not be made if there is an outstanding **overdue** balance of more than \$100.
4. Late Fees: We reserve the right to attach a late fee for any accounts 60 days overdue.
5. Collections: If it becomes necessary to send your account to collections, you will be responsible for any fees incurred for collections in addition to the billed amount, including court costs.
6. Missed appointments: Our office reserves the right to charge a fee up to \$50 per half hour of scheduled time should you miss or cancel your appointment. We require 24 business hours notice if your appointment is less than (1) hour or routine. We require 48 business hours notice if your appointment is major and requires more than (1) hour block of time. The fees are at the discretion of the office. These fees are not meant to be punitive; they only cover a portion of our operating expenses associated with the time that was set aside for you.
7. Checks: We do not accept checks as payment for a first-time visit. The fee for a returned check is \$50. along with any additional bank or collection fees or charges.
8. Minors: Must be accompanied by a parent or guardian for all appointments unless a written consent is provided. The adult accompanying the minor is responsible for full payment at time of appointment.

I agree and have read the above policies, and are in acceptance with the above.

Signed _____ **Date** _____
(By patient, parent or guardian)