KE Dental PLLC Financial Agreement

It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatment affordable to all our patients. Please review the following policies and procedures:

PAYMENT POLICY: Payment is due at the time services are rendered unless prior arrangements have been made. If you have insurance we will send you a balance statement after insurance has paid their portion.

1) We accept cash, personal checks with proper ID, money orders, Debit cards, Visa, Mastercard, or Discover.
2) If there is a balance and the charges have been on the account for over 90 days then an interest charge will be assessed at 1.5%/ month or 18%/year finance charge on the unpaid balance until paid in full unless prior arrangements have been made.
3) If your account becomes delinquent and given to a collection agency you will be responsible for any costs incurred in the collection of your debt (i.e. collection agency fees, court fees and attorney fees).
4) Fees will apply for any check that is returned by the bank.
5) MINOR PATIENTS: In the case of divorced or separated parents, it is **YOUR** responsibility to have financial arrangements made according to the divorce decree before treatments begins.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

1) You must provide us with an insurance card and/or all of the information necessary to verify your coverage and file your claim.
2) Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
3) You are responsible for all treatment charges, even if they differ from what your insurance company allows. The exception is Delta Dental Premier Insurance because we are "in-network" providers and usual and customary rules apply.
4) We will provide you with a written estimate and prior authorize with your insurance company prior to treatment (except emergency care) to the best of our ability. Knowledge of your benefits, limitations, exclusions, waiting periods, etc. is YOUR responsibility. Unforseen treatment needs or change in the course of treatment is an inherent risk in healthcare. We will do our best to keep you informed of any changes during treatment and associated costs. However you will be responsible for any charges incurred as result of treatment changes. Receiving our services indicates your acceptance of responsibility to pay.
5) All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all services we provide are covered benefits. Benefits differ from one company or plan to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment unless prior arrangements have been made.
6) Treatment provided in another dental office during your current plan year may alter your co-payment due for services in our office. We are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.
7) There are many factors in determining patient responsibilities where coordination of benefits between two insurances companies is involved. We will provide you with the most accurate information available to us but CANNOT guarantee what your out of pocket expense will be.
8) **Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations.**

BROKEN OR MISSED APPOINTMENTS: To reschedule or cancel an appointment, please notify us at least 24 hours in advance. A missed appointment fee of up to $50.00 (fee based on appointment length and/or number of appointments missed) may be assessed for missed or cancelled appointments. Missed or broken appointments prevent others from receiving the dental care they deserve. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

I have read and understand this document in its entirety; outlining the office and financial policies of Mumm and Kron Family Dentistry and agree to these terms.

Print Name: _____

Signature of patient or parent/guardian: _____ Date: _____