NORTH HARBOR
DENTISTRY

Financial Policy

We, the staff of North Harbor Dentistry, thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office at any time.

We believe this level of communication and cooperation will allow us to provide quality care to our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will honor assignment of insurance benefits, payment for services will be due at the time of service unless payment arrangements have been made and approved in advance by our staff. Any copayments, coinsurance, and deductibles will also be due at the time of service. We do our best as a courtesy to estimate any costs associated with treatment but if payment is not paid in full by insurance the responsibility is the patients.

We make payment as convenient as possible by accepting (cash, checks, money order, MC, Visa, Discover, Amex, and Care Credit). A $75.00 service fee will be charged for all returned checks.

Interest
Interest of .75 % will incur per month, 9% per year, if a balance remains unpaid after 60 days.

Insurance
Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment of services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier and any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patients responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Missed Appointments
We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $25 per hour but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without proper notification may cause you to be discharged from the practice so that we can provide care to other patients.

Timeliness of Appointments
We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

_____ _____
Patient signature/legally authorized representative Date

_____ _____
Printed name if signed on behalf of the patient Relationship