Cherry Hill Dental Smiles
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FINANCIAL POLICY

Patient Name: _____ **Date:** _____

Thank you for choosing our office to provide your dental care. We appreciate your trust and look forward to working with you. In order to prevent any misunderstanding and to better serve you, we ask that all patients read and sign our Financial Policy.

VERIFYING INSURANCE: As a courtesy to our patients, we will verify insurance for benefits eligibility prior to the first appointment as well as any time we are notified of a change in coverage. The insurance companies do not guarantee payment based on the information that they provide us. You are ***ultimately responsible*** for knowing the terms of your plan; this includes any waiting periods for work to be performed. Any amount on your treatment plan that is not covered by your insurance, except for contractual fee discounts, is your financial responsibility.

INSURANCE INFORMATION: New insurance, as well as changes in insurance, must be provided to our office **prior** to your appointment. Accepting assignment of benefit from your insurance company is the equivalent of extending you credit; therefore, we must have your Social Security Number on file. If you choose not to provide us your Social Security Number, you will be responsible for payment in full at the time services are rendered.

CHANGES IN PERSONAL INFORMATION: Changes in your address or telephone numbers should be provided to us immediately. If this office is unable to contact you by telephone or mail and your balance is overdue, your account will be sent to a collection agency.

REQUESTS FOR ADDITIONAL INFORMATION: These must be responded to immediately. Such requests include proof of a college student's full-time status and proof of continued enrollment in an insurance plan. Failure to provide this information to the insurance company in a timely manner may result in the entire balance being **your** responsibility.

PAYMENT: PAYMENT IS DUE AT TIME OF SERVICE

BALANCES: If your account balance exceeds 30 days, you will receive a notice informing you that your account is overdue. If you do not pay your balance or arrange a payment plan within 60 days, your account may be assessed a finance charge of 1.5% per month. If your account is turned over to a collection's agency a collection fee (currently $25.00) will be added to your account balance. The collection agency will report any unpaid balance to the major credit bureaus. If, for any reason, the account is litigated, the patient is responsible for all attorney and court fees.

REFUNDS: Overpayments will be refunded to the appropriate party, normally the insurance company or the guarantor. Patients' refunds will not be processed until all active or past due accounts and insurance claims have been paid in full.

RETURNED CHECKS: There will be a $30 fee for all returned checks. The amount of the check plus the fee must be paid within 10 days of notification by money order, cash or credit card.

CANCELLATIONS/FAILED APPOINTMENTS: We require that you give our office 48 hours' notice in the event that you need to reschedule/ cancel your appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $25.00 will be charged to you**; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled nor can records be transferred without the payment of this fee.

Patient or Guardian Signature: _____ Date: _____