Financial Policy

Thank you for choosing John J Andre, DDS, PC & Associates as your dental provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following information is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

PLEASE NOTE: Payment is due at the time service is provided, including copayments and deductibles. Our office accepts cash, personal checks, Mastercard, Visa, Discover, AMEX, and Carecredit. Outside financing is available upon request and approval.

◊ As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide and insurance estimate to you; however, **it is not a guarantee** that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.

◊ All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.

◊ Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

◊ We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

◊ Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for the balance on your account at that time.

◊ We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. We will not, however, enter into a dispute with your insurance company over any claim.

◊ In addition, as a courtesy, we will file a secondary claim if there is a secondary carrier, once the primary insurance company remits payment for a particular date of service. We accept the higher write off of the two dental insurances, but not both companies write offs (negotiated amounts).

Missed Appointment (s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. Multiple failed appointments may result in being charged a fee of $35 per scheduled hour and/or dismissal from the practice. Please help us serve you better by keeping your scheduled appointments.

Collections information:

I further understand that a 1.25% finance charge (15% annually, min $1.00 per month) will be added to any balance over 60 days. In the event of defaulting on my account balance, I promise to pay indebtedness, together with collection fees of 33.3% , cost of collection and interest as stated above; and waive Benefit of Homestead Exemption. I also understand that a $50.00 fee may be added to my account for all returned checks.

Multi-Household Minors

Seperated or divorced parents of minors, who are responsible for percentages of co-payments for dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. We are happy to hold a credit/debit number from the non-custodial parent on file. We will not, however, interfere or become involved in custodial disputes over any treatments or copayments.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Communications with you:

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient Name Printed _____

Patient / Guardian Signature _____

Date _____