West Ranch Dental
Ken Lahr, D.D.S.

OFFICE FINANCIAL POLICY

In order to run our office in an efficient, effective manner, we have developed some policies for the management of our patient's financial responsibilities. Please take a few minutes to familiarize yourself with our guidelines. We encourage your questions and comments.

APPOINTMENT POLICY

We see all patients on an appointment basis, doing our best to see all patients on time. We request that you arrive promptly for the time we have reserved for you. If, for any reason, you need to make changes to your appointment, we require a **48-hour notification call** during business hours, so this time may be offered to another patient. We do understand that unforeseen circumstances arise. In the event that we do not receive 48 hours notice prior to a scheduled appointment or an appointment is missed for any reason without notifying our office, we reserve the right to charge a cancellation fee of **$75.00 per hour**. **For example: This means you will be charged $225 for a three hour appointment.**

PAYMENT OF FEES FOR NON-INSURED PATIENTS OR PATIENT COPAYS

Payment is due the day service is rendered in all instances, unless other arrangements have been made in advance. We accept cash, check, MasterCard, Visa, American Express, and Discover. Please feel free to take advantage of your charge card for you visits. We also offer no interest payment plans through CareCredit Financing. This is a convenient, low minimum monthly payment program for your entire family specifically designed to pay for healthcare and elective treatment not covered by insurance. This allows you the option of paying the full amount with a single easy payment to us and you can spread your payments through your charge card over an extended period interest free.

PATIENTS WITH DENTAL INSURANCE COVERAGE

Payment of your estimated portion of your treatment is due the day service is rendered. Dental insurance is designed to assist patients with their dental needs. It is not intended to be for complete coverage for all treatment. Not all plans are the same. The extent of your benefits depends on the quality of the plan purchased by your employer. If your employer has purchased a good plan, you will have good benefits. If your employer has purchased a limited plan, then you will have restricted coverage. Please keep in mind that we have no control over the coverage purchased by your employer. We can attempt to find out your maximum and your deductible, but it is ultimately your responsibility to become familiar with your own plan. Our services and our fees are based on your dental health needs and have nothing to do with your insurance. We are more than happy to submit your dental claim form to your carrier so that you may receive maximum coverage under your plan.

Initials______________ Date _____________

SOME GENERAL INSURANCE GUIDELINES

Please be sure to know your insurance company's name, address for claims, phone number, and group number. To accurately check your insurance benefits and file your claims we will need your personal identification number or social security number, whichever applies to your specific insurance plan. Please be sure to advise us if this information changes at any time throughout the year, so that we can update our records.

You are ultimately responsible for the entire fee regardless of the portion covered by your insurance. Insurance coverage usually ranges from 50% to 90% of the treatment fees. We will do our best to present you with a treatment plan estimate; however, it is only an estimate and not a guarantee of payment by your insurance company**.**

We will do our best to collect payment from your insurance company. **If a claim is denied, downgraded, or uncollectible for any reason, any portion not paid by your insurance company will be your financial responsibility.**

CONSENT FOR TREATMENT AND INSURANCE INFORMATION RELEASE

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to diagnose my dental needs. Upon diagnosis, I hereby authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. This treatment may require the use of anesthetics, sedatives, and other medications as necessary. I understand that I can ask for a complete recital of any possible complications

I authorize the provider and staff to release any information required to process insurance claims. I understand that any portion not paid by my insurance company will be my financial responsibility. **There will be a 1 1/2 % per month (18% per year) finance charge on balances unpaid after 60 days. Insurance and patient portions are estimates provided as a courtesy. In the event that your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance.**

If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I understand that I will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting on my account.

We welcome you to our office and look forward to helping you achieve the healthy, beautiful smile you deserve.

Please print patient's name ____

Patient/Guardian Signature ____

Relationship to patient ____________________________ **Date** __________________