Financial Policy

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our Patient Information Sheets before seeing the doctor.

Unless previous arrangements have been made, all payments and co-payments are due at the time of appointment. Payment may be made by cash, check, Mastercard, Visa, Discover, American Express or prior approval from a Third Party Financing provider (our office participates with Care Credit).

Dental Benefits
We are pleased that many of you have dental benefits and our office will assist you in obtaining the maximum benefits specified in your contract. However, your benefits are a contract between you and your insurance carrier.

We will assist you in determining your benefits as best we can. Because plans differ from carrier to carrier and policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan.

Our practice is committed to providing the highest quality of treatment to our patients and we charge what is usual and customary for our area. We know how confusing insurance plans can be. If you have any questions, feel free to ask us. We may be able to help you.

<u>For Orthodontics</u>
Our office is enrolled with several insurance companies to accept assignment of benefits, or payments, for orthodontic services.
Prior to initiating orthodontic treatment your coverage will be verified and payment arrangements made for your balance.

For Pediatric Dentistry:

1. Our office is presently an In-Network provider with: Delta Dental (Premier Plan) and Horizon Blue Cross Blue Shield of NJ (Traditional Plan) We are Out-Of-Network for every other carrier and plan. If your plan allows you Out-of-Network benefits, we will gladly accept payments from your insurance carrier. You will be responsible for any balances not covered by your insurance company.
2. Co-payments quoted at the time of service are an estimate and the actual payment due may differ after your insurance carrier has paid their share of your bill. Any balance remaining after your insurance company's payment will be your responsibility.
3. Balances with benefit claims outstanding more than 60 days may be reverted back to the patient.
4. Not all services are a covered benefit in all contracts. Some carriers and employers select only some services to be covered. You are responsible for payment of all services regardless of the payable benefit.

Additional Fees

Returned Check Fee:
Our bank charges us a fee for any check that is returned for "insufficient funds" and a $40.00 fee will be added to the patient's bill if this occurs.

Aged Accounts
In the event that your account becomes delinquent for more than 60 days, you agree to pay a finance charge of 1.5% per month on any balance due, as well as reasonable collection costs, court costs, attorney fees and interest fees accrued with the collection of this account.

Appointment Policy
We respect your time and ask that you respect ours by honoring your appointment commitment. A broken appointment is a loss to everyone. Remember, once you have made an appointment, this time is reserved for you. Please give us at least 24 hours notice if you are unable to keep your appointment. This will allow us to accommodate the needs of other patients more readily. If we do not receive a cancellation notice within 24 hours, a cancellation fee of up to $50.00 per patient ($100 per family) may be applied to your account.

Responsible Party
For patients under age 18, the responsible party is the parent /guardian who accompanies the patient and completes the child(ren)'s paperwork. This may or may not be the parent under

whom the child is insured. Court documentation may be required in cases of divorce/separation to determine the financially responsible parent/guardian.

I have read the above Akkaway Orthodontics and Pediatric Dentistry's Financial Policy. By my signature I acknowledge that I understand and agree to abide by its terms.

Typing your name on the Health History Form Online applies to the following:

Signature of Responsible Party: _____
Print Name_____
Circle Relationship: SELF PARENT LEGAL GUARDIAN
Date:_____

Signature on File for Dental Insurance

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for my balance regardless of my insurance benefits.

I authorize release of any information relating to my dental claims.
X_____ _____
Signed (Patient OR Insured Parent/Guardian) Date

I assign dental benefit payments to be paid directly to Akkaway Orthodontics and Pediatric Dentistry from my insurance company.
X_____ _____
Signed (Patient OR Insured Parent/Guardian) Date