***Albright Dental Practice - Dr. John H. Albright, D.D.S.***

**Financial Policy**

It is the policy of Albright Dental Practice to have a Financial Policy that clearly outlines patient and practice responsibilities. We are committed to providing our patients with the best possible dental care while minimizing administrative costs. This Financial Policy has been developed with these objectives in mind, and to avoid any misunderstandings or disagreements concerning payment for professional services.

**Please read the following carefully:**

**For all patients:**

• Appointments missed or not cancelled within 48 hours will incur a $50.00 “Failed Appointment” Fee.

**For patients who do not have insurance:**

• Patients who do not have any insurance coverage are **expected to pay for services rendered at the time of visit.** Financial assistance may be available for qualified patients. If a patient feels that he or she may qualify for assistance, it should be discussed with the financial administrator **at the appointment check in, not after services are rendered.**

• Payment plans are available for patients who meet the minimum requirements. Please speak to the financial administrator in reference to this.

**For patients who are currently covered by insurance:**

• The patient is responsible to provide us with **valid dental insurance information, and should bring their insurance card to each visit.** The patient is responsible for notifying us of **insurance changes or new insurance information at the time of check-in for your visit.**

• Our office participates with Delta Dental Premier, Met-Life and NCAS. **We accept most dental insurance** unless we are not able to submit to them because of out of network agreements. For patients that are members of a participating insurance, we will submit a claim on their behalf to the insurance company.

• Albright Dental Practice bills secondary insurance companies as a courtesy to our patients.

**If you have a plan that our practice participates with:**

• The **patient is responsible to pay any co-payment** or any portion of the charges as specified by the plan **at the time of visit**.

• Any dental services not covered by an individual's insurance plan are the patient's responsibility and payment in full is due at the time of visit.

**If you have a plan that our practice does not participate with:**

• If a patient has insurance that we do not participate in, we will submit to the insurance company on your behalf (as a courtesy) and the difference in payment (if any) will be the patient's responsibility.

• If a patient is a member of an insurance company that mails the payment for service directly to the patient; then the patient is responsible for payment at time of service and their insurance company will send their reimbursement (if any) to their residence.

**Financial responsibility:**

• Any outstanding patient balance that is either not paid in full or under a payment plan agreement will be transferred to an outside collection agency if the account balance is not paid in full or the payment plan is not upheld by the patient.

• The patient is responsible for contacting Albright Dental Practice to inform us of any address or phone number changes. Failure to report a current address and phone number with an unpaid balance will result an outside collection agency acting on our behalf.

**Concerns about dental coverage:**

• Albright Dental Practice submits claims and pre-determinations to a patient's insurance company on the patient's behalf; however, **we do not** have an agreement of coverage with your insurance company. The agreement for coverage is between the patient and the patient's insurance company. If a patient has a concern with coverage, please contact the patient's insurance company.

• Albright Dental Practice is not responsible for what insurance companies cover or do not cover. Our concern is with providing our patients with the best dental care possible. Additionally, it is the patient’s responsibility for tracking remaining benefits. You will receive your remaining benefits at the bottom of every explanation of benefits document that you receive by mail from your insurance company directly.

**My signature on this document confirms that I have read and will adhere to Albright Dental Practice Financial Policy Agreement for myself and dependent children:**

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