BETHANY DENTAL ASSOCIATES
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FINANCIAL POLICY

This is an agreement between myself, as the responsible party, and Bethany Dental Associates as creditor on this form. In this agreement the words "you", "your", and "yours" means the responsible party. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we", "us", and "our" refer to Bethany Dental Associates.

Payment options if you have insurance:

A. Any co-payments, co-insurance and/or deductibles required by an insurance company must be paid at the time of service. This is an insurance requirement agreed upon by you (as the member) and us (the provider). Therefore, we cannot bill you for these.
B. For extensive treatment (crowns, bridges, dentures, and implants) you may choose to pay 50% of your financial obligation on the start of the preparation date and then the balance on completion/insertion date as a courtesy from ***us*** to ***you*** .
C. Pre-pay entire treatment plan. Any reimbursement from insurance will be sent to you directly.

Insurance*: Insurance is a contract between <u>you and your</u> insurance company. In most cases, we are NOT a party in this contract. We will submit the claim to your primary insurance company as a <u>courtesy</u> to you.* Although we estimate what your insurance company may not pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay the portion of charges not covered by your insurance company.
We do not submit claims to secondary insurance companies. You may submit the claim on your own and be reimbursed by the secondary insurance company.

Payment options if you do not have insurance:

A. You choose to pay by cash, check, or credit card on the day that treatment is rendered.
B. On treatment involving laboratory fees (crowns, bridges, dentures, etc.), you may choose to pay 50% on the start of treatment and the balance on completion/insertion date.

Returned checks: There is a fee of $35.00 for any returned checks from the bank.

Missed Appointment Fee: Patients who do not show up for an appointment, and/or cancel with less than 24 hours notice of the appointment time will be charged a $50.00 fee. This fee must be paid before the new appointment is scheduled. The second time this occurs, a $65.00 fee will be charged. Patients with three missed appointments will be asked to transfer their records to another practice.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. In the event that your account becomes delinquent for more than 30 days, you will be required to pay a finance charge of 1.5% per month on any account balance and a statement fee of $1.75 per statement. If we have to refer your account to a collections agency, you agree to pay us all of the collection cost and late fees which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all of the lawyers' fees plus all court costs.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit agency, the fact that you received treatment in our office may become a matter of public record.

Divorce: In case of a divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After divorce or separation, the parent authorizing treatment for the child will be responsible for the subsequent charges. If the divorce decree requires the other parent to pay any of the treatment cost, it is authorizing parent A to collect from parent B.

For patients with insurance, you hereby authorize and direct payment of the dental benefits otherwise payable to Bethany Dental Associates. You agree to be responsible for all charges for dental services, materials, and lab fees not paid by your dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with your plan prohibiting all or a portion of such charges.

For patients without insurance, by signing this agreement you hereby agree to pay for all services received, materials used, and lab fees incurred at Bethany Dental Associates.

_____

Printed name of Patient

_____

Printed name of Responsible Party/Authorized Representative (if not the patient)

_____ _____ _____ _____

Signature of Patient or Authorized Representative Date Signature of Witness (office personnel) Date

Once you have signed this agreement, you agree to all of those terms contained herein and the agreement will be in effect.

Rev 12/24