3844 Kennett Pike
Greenville, DE 19807
(302) 575-0100

Office Financial Policies (of Your Dentistry Today, Inc.)

Payment is due at the time of service

Payment Options

Choose one of the following:

"I do not have dental insurance"

- ❑ I will pay by cash or check at the time of service.
- ❑ I will pay by credit card at the time of service.
- ❑ I would like to apply for an extended payment plan so that I may take up to three years to pay.

"I have dental insurance"

- ❑ I will pay my estimated portion by cash or check at the time of service.
- ❑ I will pay my estimated portion by credit card at the time of service.
- ❑ I would like to apply for an extended payment plan so that I may take up to three years to pay.

List the dependents for which you are financially responsible:

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It is the patient's responsibility to know the limitations of their dental insurance and to inform us of any changes in your plan. Your insurance company does not inform us of your benefit coverage or of any changes to your plan. Our office can only estimate what your insurance company will pay. The dental insurance is a contract between the patient and the insurance carrier. The procedures covered are determined by the purchaser (employer) of the dental plan. Insurance companies may base their reimbursement on a Fee Guide, which could be lower than our dental fees. Therefore you are responsible for the difference regardless of the percentage. _______ (please initial)

Insurance assignment: (Please sign if you would like us to accept your insurance assignment)
As a service to you, we can accept your insurance assignment. Simply stated, we will send an itemized bill to your insurance company for the estimated portion of service performed. You must authorize your insurance company to pay us versus directly reimbursing you. **You are responsible for deductibles and co-pays at the time of service.** This office does not guarantee that your insurance will pay. If for some reason your insurance does not pay; you are responsible for the entire bill. This office will not enter into a "dispute" with an insurance company over a claim, although we will work with the insurance company to sort out any confusions or questions, which may arise. It will be YOUR responsibility to handle any dispute over payment, however we will assist you any way we can. If a dispute does arise the balance will be due to the office by you, and the insurance company will reimburse the patient.
This form is also considered the "Authorization to pay the Doctor". *I hereby authorize payment directly to Your Dentistry Today, Inc. of the insurance benefits otherwise payable to me. I understand I am responsible for all costs of treatment. I grant the right to Your Dentistry Today, Inc. to release my dental/medical histories and other information about my dental treatment to third party payers. This is my "signature on file".*

____ ________________________

Signature/Guardian Signature (for ins. Assignment) **Date**

Interest will be charged to all accounts overdue by 30 days at a rate of 1.5% per month. If a bill is unpaid 90 days or more, a collection agency will be used to manage the delinquent account and you will be responsible for all costs of collection. Patient will be responsible for all legal fees or costs associated with collection. There will be a $25 charge for all returned checks and the office reserves the right not to accept checks for future payment.

I have read and understand the Office Policy.

____ ________________________

Signature **Date**