



## FINANCIAL AGREEMENT AND POLICY REGARDING DENTAL INSURANCE

Dear Patient,

Thank you for choosing us as your health care provider. The following is our policy regarding filing your dental insurance. Our main concern is that you receive the proper and optimal treatment needed to restore or maintain your health. We do file your insurance as a courtesy to our patients, and here are some things you should know:

1. Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly.
2. Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1000. There has been no significant increase in the yearly maximum cap in over 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
3. Many people receive notification from their insurance company that dental fees are "above usual and customary". An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee and then determines that 80% of the average is customary. Included in this survey are discounted dental clinics and managed care facilities which have severely reduced fees that bring down the average.
4. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that they will not cover.
5. Returned checks and balances older than 90 days may be subject to additional collection fees and interest charges of 1.5% per month.

The patient agrees to the following (please initial):

\_\_\_\_\_ It is your responsibility to provide us with your most current insurance information. If you change insurance or fail to maintain insurance, you must notify our office immediately.

\_\_\_\_\_ If you fail to provide accurate insurance information to us in a timely manner (prior to insurance termination), your insurance company may deny your claim. If the claim is denied, you will be financially responsible for services rendered.

\_\_\_\_\_ We may accept assignment of insurance after verification of your coverage. Please be aware that some or all of the services provided may not be covered in full by your insurance company. Therefore, you are financially responsible for services not covered by your insurance company. It is your responsibility to know your benefits.

\_\_\_\_\_ Prior to receiving services, you must verify that we are participating providers for your insurance company by calling your insurance company or logging on to their website.

\_\_\_\_\_ Copayments, coinsurance and/or deductibles are due at the time of service. We will provide a good-faith estimate of the amount you owe based on information we receive from your insurance company. This will only be an estimate and in no way does it imply a contractual arrangement indicating an agreed upon amount actually due. We will not know how much is actually due by you until we receive payment from your insurance company. You are responsible for paying the full amount determined by your insurance company once they have paid your claim, regardless of our estimation. Please review your explanation of benefits or contact your insurance company if you have questions.



\_\_\_\_\_ **Full payment is due at the time of service.** We accept cash, check, credit cards and Care Credit.

\_\_\_\_\_ If you are not able to pay the balance due in full, you must contact our office directly to discuss a payment schedule. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney.

\_\_\_\_\_ We will send a statement to the billing address to notify you of any balances you may owe. If you have any questions regarding your balance, it is your responsibility to contact our office after receipt of the initial statement. Please call our office directly at (972)772-1808. We will assume you do not dispute the charges if you do not contact our office within 30 days of receipt of the statement.

\_\_\_\_\_ **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. Past due accounts may be subject to a monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity. You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable. The laws of the State Of Texas apply and venue is proper in Rockwall County.

\_\_\_\_\_ If your account is assigned to a professional collection agency, you will be notified by certified mail that you will no longer receive services other than emergency treatment from David McGaffin DDS and will be assisted in finding another healthcare provider.

\_\_\_\_\_ All returned checks are subject to a \$35 charge in addition to your original balance.

\_\_\_\_\_ You must provide a current billing address, telephone number and any other important contact information. If your information changes, please fill out our information update form in the office or call us with new information.

The undersigned hereby authorizes David McGaffin DDS to prescribe necessary x-rays, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I authorize Dr. McGaffin to perform all recommended treatment mutually agreed upon by me and to use appropriate medication and therapy indicated for each treatment. I agree to pay any collection fees if this account is turned over for collection.

By signing this document you authorize us to file your insurance claims electronically or by any other means, on your behalf as well as that of your family. This will remain in effect until you notify us in writing that you no longer wish for us to file claims for you or your family.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient Name (Printed) \_\_\_\_\_

Patient Signature  
(Or Parent/Guardian) \_\_\_\_\_ Date: \_\_\_\_\_

The "claim" is based on the services provided for any given date of service. There may be more than one "claim" as well as more than one "date of service" or "service provided". This Agreement contemplates all claims for all services rendered on any given day.