Financial Policy

The dentist of this practice works hard to keep your health care costs as low as possible. To do this, we need your cooperation in trying to keep our billing costs to a minimum. Please help us to do so in the following ways:

- **ALWAYS** bring your current health insurance card(s) and photo ID to the office for your visit.
- Please notify us right away of any changes in insurance, home address, phone numbers, etc.
- You are responsible for paying your office visit **CO-PAYMENT** at the time of service if required for your dental services, as well as any outstanding balances on your account. If you do not have insurance, please come prepared to pay for your visit in full unless other arrangements have been made.
- After your insurance payment is received, you will receive a bill for any patient responsibility and/or explanation of benefits from your carrier regarding your responsibility.

The following policies are effective as of July 1 2014:

Co-payments: We are required by all insurance contracts to collect all co-payments at the time of service. These payments can be made in cash, by check, credit card, or debit card.

Payments: Unless other arrangements have been approved by the office, the balance on your statement is due and payable upon receipt of the statement and is past due if not paid within 30 days of statement date.

Monthly Statements: If you have a balance on your account, we will send you a statement. There will be a $5.79 charge for each subsequent statement sent thereafter and a $29.00 late charge for all payments received after the due date. I agree that fees are due in full upon completion of designated treatment and if not fully paid, the balance shall carry a finance charge of 1.5% per month (18% A.P.R). I agree that any amount due is a debt and that below signed agrees to pay attorney fees for the greater or $150.00 or 40% of the total amount and court costs in collection thereof, pursuant to KRS 453.205 if any attorney is employed to collect debt.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect the debt. If we have to refer your account to an outside collection agency, you agree to pay all of the **collection and, if necessary, court costs** that are incurred.

Uninsured Patients: A patient who does not have insurance coverage through a federal, state, or local government program, or through private insurance, is considered an uninsured patient. These patients are responsible for services in full at the time of service.

Insurance: It is the responsibility of the cardholder/patient to know what his or her eligibility and coverage is with their current insurance plan. If this is unknown, the patient should verify coverage limitation prior to the appointment date. You agree to pay any portion not covered by your insurance including your deductible, co-payments and any services your insurance company determines to be "not covered" by your plan.

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of claims. To avoid misunderstandings, we wish our patients to know that all professional services are charged directly to patients. I agree to be responsible for all charges for dental services and materials not paid by my benefit plan, unless my dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charge. For those patients covered by insurance, we will accept assignment of benefits. Most policies DO NOT cover 100% of the cost of your treatment. Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of your charges the day the service is rendered. We will estimate, as closely as possible, your coverage, but until we actually receive the payment from the insurance company, it is just an ESTIMATE. We will assist you in dealing with the insurance company, but ultimately the responsibility lies with you. If, after 60 days, the insurance company hasn't paid, the balance will be due, in full, by you.

I understand by means of this policy that I was informed prior to receiving treatment that my insurance may not be liable for services rendered if any of the following conditions may apply:

- I may have an un-met deductible under my dental plan
- Services may not be covered under my dental plan
- Weaver Dental Care may be out of network for my dental plan

Secondary Insurance: We do not accept secondary insurance as payment for services.

Assignment of Benefits: I hereby authorize payment of the dental benefits otherwise payable to me, directly to the below name dentist or dental entity.

Dave Philbrick DMD, FAGD, dba Weaver Dental Care

HIPPA: I hereby state that I have been offered a copy of HIPPA Policy.

Signature: _____ Date_____
(patient, parent or guardian, if patients is a minor)

Patient Agreement

The following policies are effective as of July 1, 2013:

Appointments: A minimum charge will be made for failed or cancelled appointments without notification of 48 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still had to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved exclusively for you. **A minimum charge of $39.00 per person per ½ hour appointment will be charged to your account.** This fee will need to be paid prior to the rescheduling of your next appointment I agree that I am the responsible person (signed below) for myself, spouse, child, or relative (patient).

Certification: I certify that the patient information I have given is accurate to the best of my knowledge.

Consent: I hereby give my consent for treatment deemed necessary by the doctor for myself, for my child, if a minor.

HIPPA: I hereby state that I have been offered a copy of HIPPA Policy.

Signature _____
(patient, parent or guardian if patient is a minor)

Date_____