Lehigh Valley Pediatric Dentistry, LLC Financial Policy & Consent to Contact

Patient Name________________________________D.O.B.____________ Social Security #________________
Responsible Party____________________________________ Relationship to patient__________________
Address___________________________________ City_____________________ State___________

<u>Contact</u>:
Please complete the list of phone numbers where we can contact you. Reasons for our needing to contact you include but are not limited to the need to confirm or change appointments, to discuss insurance or payment situations, collect monies, or to respond to your inquiries, etc. Please note that this office and/or its agent(s) may contact you by telephone at any of the numbers listed below, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages. Methods of contact may include pre-recorded/artificial voice message and/or use of automatic dialing devices.

Home Phone: _______________________ Cell Phone:_________________________

<u>Payment Policy</u>:
Delta Dental & United Concordia: If you have Delta Dental, United Concordia, Aetna, Cigna or Guardian insurance coverage we will process your claims through our office. You are responsible for the charges outlined in your respective plan. Any fees you are responsible for are due when service is rendered. You should be prepared to pay any deductible and/or co-payment at the time of the appointment. If a fee is not collected at the time treatment is rendered you will be billed for it.

Other carriers: We will submit your claim as an out-of-network provider for <u>most</u> insurance carriers. We request an estimate from your insurance carrier of their out-of-network coverage and you are responsible for the remaining balance. The remaining balance is due at the time treatment is rendered. Please note that your insurance carrier will only provide our office with an ESTIMATE of your benefits and does not guarantee payment. If your insurance carrier fails to make payment, or payment is less than the estimated amount, you are responsible for the balance.

No insurance: Patients that do not have insurance must pay for treatment by cash, check, or Visa/MasterCard at the time treatment is rendered.

<u>Additional Charges/Fees:</u>
Late fees: There will be an interest rate of 1% per month (12% annually) applied to all accounts over 60 days, regardless of the insurance involvement.

Returned checks: There will be a $45.00 handling fee for any returned checks.

Broken appointments: A $40.00 fee will be assessed for each broken appointment (without 24 hour notice).

Collection fees. You are responsible for all fees incurred, including but not limited to attorney's fees and court costs, to collect outstanding balances.

I hereby certify that I am the Responsible Party and I agree to be fully responsible for payment of treatment including treatment not covered by insurance. Further, I have read this Financial Policy and Consent to Contact and I understand and agree to all terms and conditions set forth herein.

_____________________________________ ________________________
Responsible Party Signature Date