FINANCIAL RESPONSIBILITY POLICY

As a result of the many different and confusing insurance carrier reimbursement policies, it is necessary to have an easily understood financial responsibility policy.

It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service.

As a service to our patients, we will submit your insurance claim to your primary insurance carrier. Our office will provide the insurance carrier with all the information necessary to help you receive the maximum benefit from your insurance. However, it is the patient's responsibility to know the insurance coverage for their particular policy. **PLEASE BE AWARE MOST INSURANCE PLANS HAVE A MAXIMUM AMOUNT OF BENEFITS THAT THEY WILL PAY PER PLAN YEAR.**

If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient or responsible party and be be paid to us directly. You may then contact your insurance company for reimbursement.

If the patient has coverage with a secondary insurance carrier, we will submit all secondary claims directly to them along with a copy of the explanation of benefits from the primary insurance carrier.

Insurance is a patient's benefit designed to assist the patient in their financial obligations to the office of Waynesville Family Dentistry. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated in the office of Waynesville Family Dentistry.

At the time of service the office will **estimat**e the anticipated insurance payment and will collect the estimated balance along with your deductible. After your insurance payment has been received, the patient will be billed for any difference between the estimated balance due and the actual balance due. If the insurance payment is greater than what was anticipated, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied toward future treatment.

In the event that the patient does not have insurance coverage, charges for services are due payable at the time services are rendered.

Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance carrier does not cover. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance carrier to pay directly to the treating dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered and fees accumulated on my behalf or that of my dependents. I am also responsible for any balance due because of insurance claims not paid within 60 days of service.

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Name of Patient (Parent if Minor) or Responsible Party (Please Print)

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Signature of Patient (Parent if Minor) or Responsible Party **Date**