Carolina Family Dentistry at Lake Wylie, PLLC

244 Latitude Lane, Suite 103
Lake Wylie, SC 29710

Phone: 803-831-2171
Fax: 803-831-2172

smile@carolinafamilydentistry.com
www.carolinafamilydentistry.com

Financial Policy

We are pleased to welcome you as a new patient. Our primary mission at Carolina Family Dentistry at Lake Wylie, PLLC is to provide you with the most optimal dental care for your specific requirements. An important part of this mission is making the cost of care as easy and manageable for our patients as possible. As we are sure you understand, to continue providing care we must receive prompt payment for the services rendered. Your assistance in seeing that your account is kept current is appreciated!

To assist you with your dental care investment, we provide the following payment options:

1. Cash- includes money orders and personal checks

2. Visa/ MasterCard/ Discover- We accept credit cards as payment for treatment.

3. Payment Plan/ Care Credit- Patient payment plans that allow you to pay over time with convenient low minimum monthly payments. With Care Credit, you enjoy the following benefits :

*Flexible financing options
*No annual fees or prepayment penalties
*Quick and easy application
*Receive a credit decision almost immediately
*Start your recommended treatment immediately

We are happy to offer these choices so that you can select a payment option that best fits your needs.

*All patients are charged the same for services rendered. This office does not accept reasonable and customary charge calculations by outside parties, unless this office is a participating provider. Any adjustments/ write-offs will be applied upon receipt of insurance payment and Explanation of Benefits.

*Currently this office is a participating provider with:
Delta Premier, Delta PPO, and Metlife PDP

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Patients with Insurance

* The most common misconception concerning insurance is that your policy will cover the total cost of treatment fees charged. Insurance is designed to reduce your out of pocket cost, but usually will not eliminate it entirely. Your estimated portion is due at the time of service.

*Your dental treatment is not dictated on what your insurance will cover. Together, your dentist and you create your treatment plan based on what your current medical and dental needs are. We cannot limit your care to just what is covered by your insurance plan. Every plan is different and each insurance company determines what is covered. Just because a particular service is not covered does NOT mean you do not need it.

*Insurance will only be filed for plans that we are provided with at the time of service. We will not "back file/ retro-file" any claims. You must provide all insurance information at the time of service. You are responsible for filing any claims with insurance plans we were not made aware of.

*If no insurance payment has been received within sixty (60) days of service, the responsible party is fully responsible for payment of the account. Please contact your insurance company to ensure your benefits are paid on your behalf.

Remember insurance is filed solely as a courtesy to our patients.
Please help us to keep this available to all patients.

Estimate of benefits for dental treatment:

*We may not have access to all of your insurance plan's limitations and exclusions. **You, as the beneficiary of the insurance policy, are responsible for knowing your policy limitations and exclusions.** The contract for benefits is between you and your insurance company. Our only relationship is with you, the patient.

*We will prepare an estimate of insurance payment and your estimated responsibility. This is prepared using information provided by your insurance plan's representative. If the information is not current, inaccurate, or lacking in detail, the treatment plan estimate may not be accurate. **Please understand that the estimate is provided as a courtesy and <u>we do not guarantee its accuracy</u>**.

*We will assist you in understanding your benefits, but are not responsible for your benefits or what is ultimately paid by your insurance plan. Your insurance company determines the benefits provided and any discrepancies should be addressed with them. **You are responsible for verifying that all waiting periods have been satisfied prior to treatment.** Annual maximums, deductibles and percentages of coverage may be different on the day of treatment based on care received by other practitioners and the medical necessity of the procedure as determined by your insurance company.

<u>You are ultimately responsible for the full amount of the dental treatment cost.</u>

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Appointment Cancellations

Procedures that necessitate two hours or more to be scheduled may require payment in advance. This ensures that your reservation will be maintained and we can allocate the required staff for your allotted time.

At Carolina Family Dentistry we value your time and put a high priority on keeping your appointments on time. We ask that you help us achieve this goal by being on time for your appointments and **notifying us at least 48 hours in advance if you are unable to keep your appointment.**

We reserve the right to apply a cancellation or no-show fee of $50.00 for cancellations made without 48 hours prior notification.

Past Due Accounts & NSF Checks

Overdue statements will be charged a **1.5% finance charge for each month overdue**. **If the account is not paid in full within 90 days of service, your account may be turned over to a collections agency and you will be responsible for the balance due plus an additional 15% to cover the cost of collections**. A **$30 service charge** will be added for checks which are returned for insufficient funds. If legal action is required to recover past due accounts, you will be responsible for all court costs including attorney fees. **Please pay all account balances upon receipt of your bill in order to maintain your credit history and avoid finance charges.**

Acknowledgement

I understand that I am personally responsible for my account and for all services rendered including any services covered by insurance. I have received and read a copy of the office's Financial Policy. I understand and agree to the Financial Policy.

Sign Name: _____ Date: _____