ALTAMONTE DENTAL ASSOCIATES, INC.

OFFICE FINANCIAL POLICY

PLEASE READ THOROUGHLY AND SIGN THIS SHEET

PAYMENT OF SERVICES:

Payment of services is due at time service is rendered unless other arrangements are made in advance. Because discussion of payments with the doctor interferes with patient care and office operation, we kindly request that financial arrangements be discussed with the front desk if such discussion is necessary.

_____ INFECTION CONTROL FEE:

INITIAL Effective March 1, 1994, a $9.00 infection control fee will be charged per office visit. This is to cover costs of infection control, including all sterilization techniques and disposal of infectious waste.

_____ BROKEN APPOINTMENTS:

INITIAL As a courtesy, we try to call and remind our patients of their appointments. However, this is not always possible. Please display your appointment card in a prominent spot in your home as a reminder to you of your appointment. Effective March 1, 1994, a $35 fee will be added to your bill for a broken appointment. We request at least a 24 hour notice for any cancellations.

SELF PAY PATIENTS:

This category includes those with no insurance and those patients who wish or need to file their own insurance. Full payment for dental services is expected on the day the service is rendered. We accept Visa, MasterCard, American Express, Discover, checks, cash, and money orders.

PATIENTS WITH INSURANCE COVERAGE:

1. We will gladly process your insurance forms and accept payment from your insurance company, but we kindly ask our patients to pay their deductible, percent responsibility, and uncovered services <u>at the time of your visit</u>. We also ask to please complete the patient section on the insurance form. Be prepared to pay after you are seen by the Doctor. We accept Visa, MasterCard, American Express, Discover, checks, cash, and money orders.

2. Please be thorough with your insurance information if you expect us to file for you. Bring your insurance card with you and any authorization information you may have. You will be responsible for any unpaid balances due to lack of information.

3. It is at our discretion that we will charge your account with a rebilling fee if we must refile balances over 45 days old. This fee will be payable by you.

4. As a courtesy, we will file your insurance. It is <u>your</u> responsibility to make sure we receive

prompt payment from your insurance company. It is useful to maintain frequent contact with your insurance carrier to make sure they are paying as they should.

5. Your insurance will send you an explanation of benefits that explains what they have paid to our office. This is a record you must keep on file. If you do not agree with their payment, please contact the insurance company.

6. If your insurance denies payment on all or part of your account, you will be asked to pay your balance. If you do not pay in a timely fashion, your account may be subject to a monthly finance charge.

_____
INITIAL

7. Disclosure of information: I authorize Altamonte Dental Associates to release any information including diagnosis and the records of any treatments or examination rendered to me or my child during the period of such dental care, to third party payors and/or other health care practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

AS A FINAL NOTE:

**Our practice is not the cause of insurance delays and denials. We file to insurance on a daily basis.

**Remember, you and/or your employer pay the monthly insurance premiums. Your insurance company is accountable to you, not us. Do not hesitate to contact them if you disagree with their payment or to find out the status of your claims.

**If you have any questions regarding this financial policy, please call BEFORE you are seen by the doctor. The office number is (407) 774-8834.

I _____ have read and understood this letter, and fully agree to its terms and conditions.
(print name)

_____ _____
(patient or guardian signature) (date)