DONNA THOMAS MOSES, D.M.D., P.C.

Practice Limited to Periodontics and Dental Implants

Statement of Financial Policy for Professional Services

Welcome to our practice. We hope to make your visits as pleasant as possible. Unfortunately, aside from the emotional and physical impact of any treatment, there is all too often a degree of financial impact as well. Your review of our financial policies at this time greatly helps avoid any possible future misunderstanding(s) and thus allows everyone to be more efficient.

1. Our relationship and our contract is with you. **We do not provide dental services to your insurance company. and have no responsibility to assure that the insurance company is pleased with your dental care**. **We will not short-change your dental care to satisfy any insurance company**.

2. Any contract that exists between you and any third party (insurance company, employer, etc.) for dental, medical or surgical care reimbursement does not obligate us to comply with the provisions of your policy. We will assist you with filing your claims, completing forms and pre-certification. **The ultimate responsibility** for the correct filing and processing of claims, however, remains with you and your third party. If you are unsure of any specific requirements of your third party, please ask them. **Do not depend on us to be familiar with every type of insurance and plan**.

3. **As a courtesy**, we may assist you in the filing of insurance claims for your **primary insurance** policy.

4. In general, we do not have contracts with insurance companies.

5. As a recipient of dental care, you must pay for services whether or not they are covered by your insurance. Insurance coverage is determined by **your** contract with your insurance company.

6. Often insurance companies will use the term "**Usual and Customary**", or similar such language when **denying** charges for dental care. **The implication is that the Doctor charges too much** for a given procedure. Universal "Usual and Customary" fee schedules **Do Not Exist**. The amount an insurance company reimburses for a procedure will vary with the company, the type and quality of policy, the zip code where charges were made and sometimes even the age or health of the patient. Our fee schedule is the same for everyone!

7. CANCELLATION POLICY: We require you to inform our office of a cancellation or rescheduling of any appointments at least 1 (one) business day before the appointment (Monday 9 am appointment needs to be canceled before 9 am the Friday before). Due to the nature of our dental practice, and the advance planning of all major treatment (surgery), such notice is mandatory. Shorter notices prevent us from efficiently operating our practice and unfairly prevent other patients from receiving needed care. Our facilities operate on a fixed schedule and limit the total time available to treat our patients. Without this 24 hour advanced notice, you will be charged $100.00 (one hundred dollars), which must be paid in full before another appointment is scheduled. This fee will be enforced and is similar to other industries which charge for space, commodities or time.

   _________ **patient's initials**

8. The patient understands and agrees that he/she is responsible for all amounts due, and further agrees to pay any fees (including attorney's fees and other costs) associated with the collections as well as interest in the amount of 1.5% per month on amounts due more than 90 days.

9. Any person with financial responsibility for a patient, regardless of the patient's age, will have access to information regarding treatment, health, finances, etc for the patient.

We are all too aware of the current nationwide crisis in healthcare financing. Quality, personalized dental care is sometimes of necessity quite expensive. Despite the pressures to pass along increased costs to the patient, we work hard on your behalf to contain fees and other charges. We are here to serve you for your dental needs. If we have done well, please tell your family, your friends and your referring doctor. If we have not, please tell us! ***I have read and understand the above. I understand that I may receive a copy of this form upon request.***

Patient Name	Patient Signature or Responsible Party	Witness	Date

4/08