|  |
| --- |
| **FINANCIAL RESPONSIBILITY POLICIES** |
| http://ts4.mm.bing.net/images/thumbnail.aspx?q=1604082076999&id=5a7cc496e778ba8e2fcc6e6c84322f84&url=http%3a%2f%2f4.bp.blogspot.com%2f_9AMxAVZ-5hI%2fR0IORjbVRnI%2fAAAAAAAAABs%2fSzWz5Y4f-9c%2fs320%2fImage15.jpg**DOREEN E. GUNDER, DDS** | **SECTION A: FINANCIAL POLICY****Payment in full is expected at the time of your service, and in appreciation you will receive a courtesy discount.** Exceptions will be given to patients with **United Concordia National Fee for Service network, Delta Dental Premier Network, BlueCross Dental and Guardian**, as we participate with these insurances. **In this instance, the patient will be required to take care of any co-payments, deductibles, and non-covered services.** If a balance remains after the insurance payments and adjustments, the patient will be billed the difference. We will process all other insurance claims and payments will be sent to the subscriber. **Due to the number of different plans through each insurance carrier, it is important that you familiarize yourself with your insurance coverage.** If you have any questions regarding your insurance, our office manager will be happy to assist you. All patients will receive our professional service. The insurance company is responsible to the patient, and the patient is responsible to the doctor.**If a financial arrangement is necessary, please leave the office staff aware before the scheduled appointment.** Our office offers Care Credit to allow patients to make payments on their balance. A patient’s ability to use Care Credit is based on approval and available credit line. Any returned (NSF) check will result in an additional **$50.00** re-processing fee.Accounts outstanding more than 30 days from the statement date will bear a late fee of $5.00 per month. **IN ORDER TO AVOID A $5.00 RE-BILLING FEE, AMOUNT MUST BE PAID WITHIN 20 DAYS OF BILL DATE.** **IF AN AMOUNT IS OVER 60 DAYS PAST DUE, AFTER YOUR INSURANCE HAS PAID, SETTLED OR SPECIAL ARRANGEMENTS MADE, YOUR ACCOUNT WILL NO LONGER BE HANDLED BY OUR OFFICE, IT WILL BE MANAGED BY A COLLECTION AGENCY.** Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_Dentist Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**SECTION B: NOTICE OF REIMBURSEMENT DIFFERENCE**The dental procedures recommended to you may involve new materials and/or different laboratory techniques which may exceed the reimbursement level of your insurance contract. In this situation, a participating provider may bill to their charge. **Any difference between the provider’s charge and the allowance is the subscriber’s responsibility.**I accept responsibility of the difference for posterior composites and any procedures meeting the criteria listed above.Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**SECTION C: NOTICE OF LATE CANCEL / FAIL POLICY**It is the patient’s responsibility to be aware of when your appointment is scheduled. As a courtesy, our office will call to remind you of your appointment. We ask that you return our call to confirm that you received our message and that you will be keeping the appointment. **If you are unable to give us a 24 hour notice when canceling an appointment, to allow us to offer the appointment to another patient, we reserve the right after repeated missed, late cancelled (less than 24 hours), or failed appointments to dismiss you from our practice and, if necessary, transfer your records to another dental practice.**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ |

2120 Fisher Road, Mechanicsburg, PA 17055 ◊ 717.795.9392 phone ◊ 717.795.5495 fax ◊ office@doreengunder.comcastbiz.net

Welcome to our practice!

On the reverse of this page, you will find our

Financial Responsibilities Policy.

We ask that you please read it carefully

and feel free to ask us any questions

that you may have.

Once you have reviewed our policies,

we ask that you complete and sign the form.

We are happy to have you as a new patient

and look forward to providing you with

excellent dental care.