Cochecho DENTAL

51 Webb Place Suite 200
Dover, NH 03820
Phone (603) 742-3321
Fax (603) 749-6806

FINANCIAL/OFFICE POLICY FOR COCHECHO FAMILY DENTISTRY

We are committed to providing you with the best possible care. Our professional fees can be discussed with you at any time. Your understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our financial policy, fees, or what your responsibility is. **All patients must complete and understand this form before seeing the doctor or hygienist.**

- Full payment (or co-pay) is due at the time of visit. We accept cash, check, Money Order, Visa, Master Card, Discover
- Any balances at or over 30 days are subject to a $10.00 late fee. This fee will continue to be added every 30 days with each missed or late payment.
- Balances over 60 days are subject to an outside collection effort.
- Patient/Guarantor will be responsible for all late, collection, and attorney fees if necessary.

Insurance Policy

If you have insurance, we will assist you to receive maximum benefits but we do not guarantee any information we are given from your insurance company. It is you, the patients, responsibility to call and know what your benefits are and to know if you have used any of your maximum. We require your co-payment to be paid at the time of service. **The balance is your responsibility whether your insurance company pays or not.** Pre-estimate of benefits is never a guarantee of payment by your insurance. At the time of your appointment, please let us know of any insurance changes you may have had since your last visit.

Your insurance policy is a contract between you and your insurance company only. We are not a party to that contract. In the event we do not accept assignment of benefits, we require payment in full by the patient. If your insurance company has not paid your account in full within 30 days, the balance will be the responsibility of the patient. Some or perhaps all of the services provided may be “non-covered” or are not considered “reasonable and customary” under your dental plan. These services are then the responsibility of the patient. You are also responsible to know what your maximum benefit is and how much you have remaining at the time of your visit. Due to privacy policies we are unable to track your benefits and cannot find out if benefits have been used elsewhere, therefore we are not responsible for any unpaid claims.

If you have a dispute over a balance because your insurance company did not pay in accordance with any kind of pre-authorization, please understand that this dispute is not with our office but is with your insurance company. This balance is due in full within 30 days of your first billed statement. We will continue any proceedings needed to collect this balance.

For some Blue Cross and Blue Shield insurance plan members: Your insurance company will pay all claims to you directly. We do not receive a check from them. Your balance will be due, in full, the day of your visit.

No Insurance Policy

Adult patients or the parent/guardian accompanying a minor are required to pay the full amount due at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized. Patients may keep a credit card on file (please ask for Credit Card Authorization form). We do not have an in-office payment plan.

Missed Appointments

If you cancel your appointment without 24 hours notice or do not show for your appointment, a charge of $50.00 will be added and billed to your account to cover the cost of reserving the doctor’s or hygienist’s time.

HIPAA – Notice of Privacy Practices

Our Notice of Privacy Practices is available to any patient, at any time. A laminated copy is available for instant review at the main office front desk. Copies of this policy are also available for patients to take, and are located at the main office front desk in a comprehensive brochure format. I acknowledge having received a copy (or having been offered a copy) of the practice’s Notice of Privacy Practices.

I authorize that I have read the entire financial policy and I understand and agree with it.

______________________ Print Name

__________ Date

X ______________________ Authorized Signature