LANCASTER SMILES

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FINANCIAL POLICY and AGREEMENT

We value our patients and are committed to the highest quality of care from our Doctor and Staff. We are happy to discuss our fees or office financial policy at any time.
A Driver's License and any dental and medical insurance cards must be presented the day of your visit and will be scanned or photocopied for our records.

NON-INSURED PATIENTS

Payment for dental treatment is due the day services are rendered. I understand that fees will be collected by the front desk at the time of service. We accept cash, personal checks, Visa, Master Card, Discover, Amex and Care Credit. Our office can assist you if interested in applying for Care Credit.

INSURED PATIENTS

As a courtesy, we will submit claims to your insurance carrier on your behalf for any services rendered by our office. Patients covered by an insurance carrier who pays the patient directly will be considered non-insured and must follow the office financial policy for non-insured patients. A receipt will be provided to you at the time of payment which you can forward to your insurance carrier for reimbursement.
Insurance coverage is a benefit of the patient, not our facility. It is your responsibility to know the specifics of your policy. As a courtesy to our patients, we will obtain information available regarding your plan coverage and will provide an estimate of your expected co-pay for recommended treatment (upon completion of your consultation.) Our estimate will be as accurate as possible. Please understand that the fees paid by your insurance company are according to their own fee schedule, not necessarily the actual fees and cost of treatment performed by our office. Any estimated patient co-pays will be collected by the front desk at the time of service. Unfortunately, we may not be aware of your specific plans limitations which may result in a payment that differs from our estimate or actual cost of your treatment such as:

- Missing tooth clause
- Procedures which are not a benefit
- Inaccurate information received from the patient
- Annual benefit maximum being reached
- Changes or termination of coverage

FEES RESULTING FROM LIMITS AND EXCLUSIONS ARE THE PATIEN'S RESPONSIBILITY.

- I understand and agree that I am responsible for payment of all charges on my account regardless of any estimates of fees and/or insurance coverage benefits provided by my insurance carrier.
- I understand and agree that after my insurance carrier processes my claim(s), there could be a balance still remaining to be paid by me and must be paid immediately upon receipt of statement.
- I understand and agree that if my account is placed into collection action, I will be responsible for all the costs of such action including but not limited to collection agency fees, attorney fees and District Justice fees.
- I understand that I am responsible for any fees as a result of a bad check and that a claim will be filed with the Bad Check Restitution Program of the Lancaster County District Attorney's Office.
- I hereby authorize payments directly to Lancaster Smiles family & Cosmetic Dentistry, P.C. for insurance benefits otherwise payable to me or I will follow the non-insured patient financial policy stated above.

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Patient or Legal Guardian Signature	Print Name	Date