Patient Responsibility Agreement

Account #_____

Initial each section after reading

Print First & Last Name: _____

Payments **Initials: _____**

- I understand that all copayments are due at the time of service.
- I understand that if I have an outstanding balance, it must be paid before seeing the doctor unless other arrangements have been made with the billing department prior to the appointment.
- I understand that all cosmetic procedures must be PAID IN FULL at the time services are rendered.
- I understand that it is my responsibility to inquire about final costs before I choose to have any procedures performed.
- I understand that I am responsible for 100% of my bill if insurance isn't reconciled in 60 days.
- A monthly finance charge of 1.5% will be applied to all accounts overdue more than 30 days. A monthly billing charge of $10 will be applied to all accounts overdue more than 60 days.
- I understand that if my account is sent to the collection agency, I will be responsible for my balance plus all collection agency charges and fees.
- I understand that payment options in the office include cash, check, debit card, MasterCard, Visa, Discover, American Express and CareCredit.
- I understand there is a $35 fee for any returned checks to the office.
- I understand that the office no longer does any type of discounts.

Insurance **Initials: _____**

- I understand that it is my responsibility to find out before being seen at each visit if my dentist is considered in-network or out-of-network with my insurance company.
- I understand that if my insurance is out-of-network, a credit card must be kept on file and automatically run if any balance is remaining after insurance pays. If a credit card is not given, payment will be due in full and insurance papers will be given for reimbursement.
- I understand that as of 1/1/15, all providers are considered out-of-network with MetLife, which includes Military. If you have MetLife, please check to see if your plan pays any differently for out-of-network.
- I understand that Dr. Lawrence Rosenman, Dr. Sara Brendmoen, Dr. Stephen Tupman and Dr. Alan Ho are considered in-network with Aetna PPO, BCBS PPO plans, Delta Premier and United Concordia National Plans.
- I understand that Dr. Lisa Marvil, our periodontist, is an independent contractor who only participates with Aetna PPO & Delta Premier.
- I understand that the office recommends that you call the office during your open enrollment to check to see if there have been any changes to the plans that we accept.

Cancellation Policy **Initials: _____**

- I understand that even though the office calls to confirm appointments, it is ultimately my responsibility to remember my appointment.
- I understand that if I fail to cancel/reschedule my appointment at least 24 hours in advance, I will be charged a minimum $35 failed appointment fee. There is a minimum $100 fee for longer appointments. 48 hour notice is required for all evening and Saturday appointments. 72 hour notice is required for all Dr. Marvil appointments.
- I understand that I must call the office to cancel any appointment. Appointments cannot be canceled by text or email.
- I understand that if I have more than 2 failed appointments in any 18 month time period, I will be required to pre-pay for all of my future appointments. If I fail a Saturday or evening appointment, I will not be given another Saturday or evening appointment.

HIPAA Policy **Initials: _____**

- I have been given a copy of Springfield Lorton Dental Group's HIPAA policy to read. Copies are available upon request.

Patient Consent **Initials: _____**

I understand that providing proof of my insurance does not hold Springfield Lorton Dental Group responsible for verifying this information. I accept financial responsibility in understanding my insurance benefits at the time services are rendered. I understand that is my responsibility to notify the office of any changes to my insurance information (new prefix to ID#, new group #, claim submission address, etc.), or personal address or phone information.

I will cooperate with the billing department of Springfield Lorton Dental Group to ensure payment for my services. I understand that I will be responsible for any costs associated with the collections of my account if I default on this agreement. I understand the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent/legal guardian of said patient and agree that I am responsible for all payments for all services rendered to the patient herein.

List of all patients that this financial agreement applies to (please list spouse and kids if you want them included):

_____ _____

_____ _____

_____ _____

_____ _____

INSURANCE INFORMATION

Primary

Policy Holder's Name _____ DOB_____ ID# _____

Policy Holder's Employer _____ Insurance Company Name _____

Insurance Company Address _____ Group # _____

Actively Employed or Retired (circle one) Effective Date of coverage_____

Secondary

Policy Holder's Name _____ DOB_____ ID# _____

Policy Holder's Employer _____ Insurance Company Name _____

Insurance Company Address _____ Group # _____

Actively Employed or Retired (circle one) Effective Date of coverage_____

Your agreement with the insurance company is between you and your insurance company. Any assistance by the doctor and/or staff in filing of insurance papers or confirmation of insurance payments is strictly given as a courtesy and implies no responsibility on their part for follow up confirmation. If the insurance company does not remit payment within 60 days after the date of service, we will bill you with the remaining balance due and payable upon receipt from you. We are happy to file necessary forms to ensure that you receive full benefits of your policy, but make no guarantee of payments or any estimated coverage.

GUARANTEE OF CREDIT CARD (Must be filled out for all out of network insurance plans)

Credit Card # _____ exp. date _____ Billing Zip code_____

Name on Card _____Signature _____

This signature on file is my authorization to release any information to the insurance company to process my claim. I hereby authorize payment of my group insurance benefits to the dentist if any claims were filed by the dentist. I hereby certify that I fully read the above and agree with all terms and conditions.

_____ _____

Printed Name of Patient/Parent/Guardian Date

_____ _____

Signature of Patient/Parent/Guardian email address