

SPRINGFIELD LORTON DENTAL GROUP

FINANCIAL AGREEMENT

ONE AGREEMENT IS GOOD FOR EACH ACCOUNT AND IS VALID UNTIL YOU REQUEST AN UPDATED FINANCIAL AGREEMENT.

PAYMENT ARRANGEMENTS ARE REQUIRED AT THE TIME OF YOUR VISIT

We now offer the following payment options: (Please choose one)

_____ **PAYMENT AT TIME OF SERVICE**

(We accept Cash, Check, Debit Card, MasterCard, Visa, Discover & American Express)

Entire fee is due the day of treatment (special arrangements may be made for some cases over \$1000)

_____ **INSURANCE** (IN NETWORK-some **BCBS** PPO plans, **Delta Premier**, **Aetna** PPO and the **United Concordia** National plans)

Dr. Lisa Marvil is only a provider with Aetna PPO & Delta Premier (*she is not a provider with BCBS or United Concordia*)

All other insurance companies are considered OUT OF NETWORK

Office will submit claims for you to insurance and estimate your co-payment at the time of service. **The estimated co-payment is due at the time of service.** If there is a remaining balance after insurance pays, it will be billed to a credit card on file or a statement will be sent to you, which is due upon receipt.

_____ **INSURANCE** (OUT OF NETWORK)

Please choose between the following two options:

_____ Patient must pay in full at time of service and we will provide you with insurance forms to submit for direct reimbursement from insurance company.

_____ Office will submit claims in full to your insurance company. **The estimated co-payment will be due at the time of service.** Any remaining balance after insurance pays will automatically be billed to a credit card left on file with our office. **(A credit card must be put on file in order to submit to out of network insurance companies.)**

Account # _____ exp date _____ Signature _____

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 insure that you receive full benefits of your policy, but make no guarantee of payments or any estimated coverage.

EXTENDED PAYMENT PLAN is always available for amounts over \$2000.00 if credit is approved beforehand

This option allows you to pay Chase Health over 1 year, interest free. Please see the front desk for an application if you are interested. Application must be approved **BEFORE** work is started. For services under \$2000.00, a 10% surcharge will be added to the total cost and will be collected at the time of service.

INSURANCE INFORMATION

Policy Holder's Name _____ DOB _____ ID# _____

Policy Holder's Employer _____ Insurance Company Name _____

Insurance Company Address _____ Group # _____

FEES & PAYMENTS

Please give at least **24 hours notice** if you are unable to keep your appointment, otherwise you will be billed for services scheduled.

The parent that accompanies the child is responsible for their visit.

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.

All accounts that are overdue more than 90 days are subject to be turned over to a collection agency. In the event that this account is placed in the hands of a collection agency, interest will accumulate in the amount of 1.5% per month from the day the services were rendered, as well as attorney and collection fees, court costs and filing fees.

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 have fully read the above and agree with all terms and conditions.

Print your name here

Signature _____ Date _____

For office use only:

Account # _____

Name _____