**Patient Responsibility Agreement**

Account #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*\*Initial each section after reading\**

***Print First & Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Payments Initials: \_\_\_\_\_\_**

* I understand that all copayments and balances are due at the time of service.
* I understand that if I have an outstanding balance, it must be paid before seeing the doctor.
* 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 all of our dentists are considered in-network with Aetna PPO, BCBS PPO plans, Delta (Premier Only) and United Concordia National Plans.
* 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 Saturday appointments. 72 hour notice is required for all Dr. Traboulsi 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 appointment, I will not be given another Saturday.

**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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred phone number

FOR OFFICE USE ONLY: Entered by\_\_\_\_\_\_\_\_\_\_\_