FINANCIAL POLICY

Arch City Dental, LLC

6343 Presidential Gateway, Suite 100

Columbus, OH 43231

We at Arch City Dental, LLC are pleased you chose us to facilitate and care for your dental health needs. **In order for us to keep costs as low as possible, we require that payment is made at time of service.** The following is a statement of our financial policy, which we require you read and agree to prior to treatment.

PAYMENT OPTIONS:

1. We accept Cash, Checks, Master Card, Visa, American Express, Discover, and Bank Debit Cards.
2. We offer a 5% discount to patients who pay in full at time of service with cash or check. Insured patients can take advantage of the same 5% discount by paying for treatment in full and accept to be reimbursed by their insurance company. (Excludes Delta Dental and PPO subscribers).
3. Six and Twelve months same as cash third party financing is available for those who qualify.
4. Those 65 years of age and older receive a senior discount.
5. Any outstanding balance will accrue a finance charge after 60 days.

INSURANCE:

For those patients who have financial assistance from insurance, your estimated co-insurance amount is due at this time. We will continue to submit your claim for you; however, your insurance is a contract between you, your employer, and the insurance company. As your dental provider our relationship is with you, not the insurance company.

All charges incurred are the responsibility of the patient regardless of your insurance coverage. We will cooperate fully with the regulations and requests of your insurance company that may assist in your claim being paid. Disputes or denied claims should be directed to your insurance carrier and/or employer.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received within 60 days from the date of filing, or claim is denied, you will be responsible for paying the full amount at that time. If we receive any payment from your insurance company and you have paid your bill in full, we will remit the payment directly to you.

EMERGENCY PATIENTS:

We require full payment for those seen for emergency appointments. We will file any insurance claims and reimbursement directed to you for this initial visit. Once established as a patient of record we will then only require your co-insurance at time of service.

MINORS OF SEPARATED OR DIVORCED PARENTS:

When two parents are each responsible for portions of a child's dental care, **the Parent or Guardian who brings the child is responsible** for co-insurance and full fee at date of service. They are also responsible for collecting payment from the other parent. Prearrangements must be made with our office if another party will be bringing the child for his appointment.

RETURNED CHECKS/NSF:

A $50.00 fee will be assessed for all returned or NSF checks. We reserve the right to reject check payments once an NSF occurs.

SHORT NOTICE CANCELLATIONS AND BROKEN APPOINTMENTS:

Each appointment is a reserved time for you and only you. Each time appointments are not kept; other patients who do value their reserved time for treatment are penalized. A $50.00 or more charge may be assessed for cancellations without a 48 hour notice of a missed appointment. We reserve the right to decline future appointments unless paid in full. We may also require your next visit be secured with a credit card deposit. This office and situation will determine when this should occur.

I have read and understand the financial policies of Arch City Dental, LLC. I understand I am responsible for all fees incurred for my dental treatment.

_____ **Patient Initials**

I understand insurance plans are payment assistance programs; they are not designed to cover the entire cost of treatment. I understand my insurance carrier may pay less than the actual bill for services. By signing this form I have authorized assignment of benefits directly to Northeast Family Dental.

_____ **Patient Initials**

I understand I am responsible for any and all charges that might occur if my account is turned over for collections.

_____ **Patient Initials**

Signed_____ **Date:** _____

(Patient Signature)

Parent or Guardian of _____

(Name of Minor)