FIRST STATE DENTAL, P.A.

FINANCIAL RESPONSIBILITY POLICY

Patient Name: ____ (PLEASE PRINT)

For all patients it is necessary to have an easily understood financial responsibility policy whether or not there is dental insurance coverage involved. If there is dental insurance, as a result of the many different and confusing insurance company reimbursement policies, it is important for patients to understand how First State Dental, P.A. will assist you with your insurance. The treatment recommended is based on the patient's need and not by what any insurance company will cover. Your treatment should not be governed by your insurance contract, which is a contract between you and your insurance company. While we would be happy to answer questions to help you understand your insurance coverage, your best resource would be to check with your insurance carrier directly. All patients/responsible parties must sign this form prior to being treated.

- It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **Prior to or at each scheduled appointment,** we need you to provide your current insurance information for our files, to ensure claim(s) can be accurately submitted. It is your responsibility to inform First State Dental, P.A. of any insurance changes or any personal changes that will impact your insurance coverage.

- As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. However, it is the patient's responsibility to determine and understand the details, restrictions, and benefit limitations of your particular policy. First State Dental, P.A. is not responsible for whether or not a service performed is a covered benefit and therefore will not assume responsibility for the insurance company's refusal to pay a claim. PLEASE BE AWARE MOST INSURANCE PLANS HAVE A MAXIMUM AMOUNT OF BENEFITS THAT THEY WILL PAY PER PLAN YEAR.

- If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.

- If the patient has coverage with a second insurance company, we will submit all secondary claims directly to that insurance company along with a copy of the explanation of benefits from the primary insurance. As coordination of benefits is unpredictable, payment from the secondary insurance coverage may be paid directly to the patient.

- Insurance is a patient's benefit designed to assist the patient in their financial obligation to the office of First State Dental, P.A. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated in the office of First State Dental, P.A.

- At, or prior to the time of service, we will estimate the anticipated insurance payment and will collect from you the estimated balance due, along with any deductible which applies, unless a signed financial agreement has been approved. First State Dental, P.A. cannot guarantee any estimated coverage. After the primary insurance payment is received, the patient will be billed for any difference between the estimated balance due and the actual balance due. If the insurance payment is greater than what was anticipated, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied toward future treatment.

- In the event that the patient does not have insurance coverage or the insurance company sends the insurance payment directly to them, CHARGES FOR SERVICES ARE DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED, unless a signed financial agreement has been approved.

- For your convenience, we accept cash, check, Visa, MasterCard, and Discover. Also, we offer dental payment plans through third party lenders. First State Dental, P.A. reserves the right to charge the account for any check returned unpaid by the bank. If a check is returned unpaid, your personal checks will no longer be accepted.

Insurance benefits are estimates only. I understand the insurance company makes the final determination of payment and eligibility and they may pay less than the actual bill for services and less than what may have been predetermined by them. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I am also responsible for any insurance claims not paid within 60 days of service. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. Furthermore, I understand that First State Dental, P.A. reserves the right to charge a monthly billing fee and to use a Collection Agency for the collection of my account and will charge that account any collection fees involved including, but not limited to, the greater of an additional twenty percent (20%) of the amount due or any reasonable attorney's fees allowable, plus pre-and post-judgement interest and court costs. If legal action is initiated to collect amounts due, I agree to pay pre and post judgment interest, court costs and attorney's fees that may apply, as allowed by the law and the court. I further understand if my account is sent to collections, all scheduled appointments will be cancelled and no dental services will be provided until the account is paid in full. __________ **INITIALS**

I have read and understand the above and I agree to be responsible for payment of all services rendered and any billing and/or collection fees accumulated on my behalf or that of my dependents.

Name of Patient (Parent if Minor) or Responsible Party (Please Print)	Social Security Number of Responsible Party
Signature of Patient (Parent if Minor) or Responsible Party	Date

Signed at: First State Dental, P.A. 1702 Lovering Avenue Wilmington, Delaware 19806