

# Premier Dental Partners, LLC.

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We, at Premier Dental Partners, LLC. thank you for choosing our dental office. Our expert team is looking forward to serving all of your dental needs. We have found that a clear understanding of what your dental needs are and the financial responsibility for your care are very important. Our policy is to provide each patient with a written estimate of recommended treatment. Our business staff will provide estimated costs to you. Please read the following policy guidelines and familiarize yourself with your insurance coverage.

## To Our Private Insurance Patients:

- As a courtesy to you, we will be happy to submit for pre-authorization and/or payment to all insurance companies with a completed and signed insurance form.
- We will initially ask you for only your estimated co-insurance payment. Please understand that this is only an estimate, and is based upon the accuracy of the information available to us from your insurance provider. We will also be unable to carry balances unpaid by the insurance carries longer than 90 days after the initial submission of claims. After three months, we will require all patients to pay their balances in full and be reimbursed directly from their insurance companies. We reserve the right to pursue all delinquent accounts via a third party collection agency or attorney.
- Please familiarize yourself with you dental benefits so as to be aware of deductibles, restrictions, time restraints, yearly maximums, and your percentage of financial responsibility.
- **We would like you to understand fully the ultimate responsibility for payment is yours.**

## To Our HMO Insurance Patients:

- The patient is responsible for eligibility in their insurance program. Patients not listed on our insurance print out are responsible for payment of our office fees in full at time of treatment.
- Due to greatly reduced fees, all patient's co-payments are due at the time of service.

## To All of Our Patients:

- **All patient co-pays are due at the time services are rendered.** For your convenience, we accept: Cash, Personal Checks, MasterCard and Visa.
- All patients having an existing account balance that is past due will not be rendered service until balance has been satisfied. All future treatment will be placed on hold until the balance is paid in full.
- We reserve the right to charge a \$75.00 fee for all returned/bad checks.
- **We reserve the right to charge for broken and cancelled appointments. We require 24 hours notice for all routine visits and 48 hours notice for all surgical and more extensive appointments.**
- We strive to be as accommodating as we can. However, if you arrive late for an appointment and we determine that proceeding with your appointment will create a negative impact on our staff, doctors or other scheduled patients, you will be rescheduled and may be subject to a cancellation fee.
- All patients under the age of 18 **MUST** be accompanied by a parent or legal guardian on **all** visits.

I have read and fully understand the terms stated above.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_