Baccellieri Family Dentistry

Financial Responsibility and Cancellation Policy

- It is important for you to provide the office with complete insurance information at every appointment (and update any changes.)
- As a service to our patients, we submit claims to your insurance company with all necessary information to maximize your benefit. However, ultimately it is the patient's responsibility to know insurance benefits for your particular policy as it is your relationship with the insurance company.
- If a claim is denied, we will research the rejection and resubmit to insurance with treatment clarification, imaging or explanation if necessary. However, if the rejection is correct, the cost becomes the responsibility of the patient.
- If patient has secondary insurance, we will submit secondary claim. The insurance companies will coordinate benefits and we will bill you any remaining balance after both insurances have responded (this typically takes 90 days or more.)
- In the event that a patient does not have insurance coverage, has "out of network" coverage or insurance pays the patient directly, we will collect for services rendered in full at date of service.
- At the time of service, the office will estimate insurance payment and will collect the estimated copay.
- Regardless of insurance coverage, the patient is receiving services so the patient is ultimately responsible for all charges on account.

We value our time with our patients and the relationships we build. We trust that when we reserve an appointment for you, you will value our time as well. While emergencies do arise, we require 24 hours notice for any change to your appointment and will happily make adjustments. In the event that you "break" more than 1 appointment (i.e. - no show, same day cancellation,) a fee will be charged to return to our schedule.

I understand that I am responsible for any copayments, deductibles and fees of services that my insurance company does not cover. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to third party payers and/or health care practitioners. I authorize and request my insurance company to pay the dentist directly those insurance benefits that otherwise are payable to me. I understand that my dental insurance carrier may pay less than the actual bill of service and I am responsible for payment of the difference of services rendered.

_____

Printed Name of Patient (or Responsible Party)

_____ _____

Signature of Patient (or Responsible Party) Date

PLEASE TURN OVER ----→