Kathryn J. Sudikoff, D.M.D., P.L.L.C. **Info@identaldilworth.com**

IDental Dilworth **(704) 632-9922 fax (704) 632-9933**

1315 East Boulevard, Suite 260

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Financial Policy

This is an agreement between Kathryn J. Sudikoff, DMD, PLLC., as creditor, and the patient/debtor on this form. In this agreement the words "you", "your", and "yours" mean the patient/debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Kathryn J. Sudikoff, DMD, PLLC

By executing this agreement, you are agreeing to pay for all services that are received.

Payment for Services*: Payment is due at the time of service. Co-pays or deductibles are also due at that time. All charges are your responsibility, whether your insurance company pays or not. After your insurance pays any remaining balance on your account, is your responsibility and is due within 30 days.*

Payment Options Without Insurance: Cash, check, MasterCard, Visa, American Express or Discover and we offer special financing through Care Credit. If you pay them within 12 months, no interest accrues to the account. (Read brochure for details)

Payment Options With Insurance: You must pay your required deductible and co-insurance portion at the time of service. You may pay by cash, check, Mastercard, Visa, American Express, Discover or Care Credit.

Insurance: We are contracted with Delta Dental Premier, Cigna Radius, and Metlife. If we are contracted with your insurance company, we must follow the requirements of our contract. We are required to collect at the time of service a deductible or co-insurance portion owed. Your benefit plan is a contract between you and your insurance company. Your benefit plan is negotiated between your employer and the chosen insurance company. Insurance companies will not cover all dental fees or services. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. Some services provided may be non-covered services and not considered "reasonable and customary" under your specific insurance plan. This does not dictate what treatment is recommended for your health or change the treatment plan of the doctor; rather it is the limitation of the benefit allowed for that type of procedure. As a courtesy, we will file all insurance claims whether contracted or not and try to maximize your benefits that you are eligible to receive. If your insurance company requires a referral or preauthorization, you are ultimately responsible for obtaining it. By signing this agreement you understand you are ultimately responsible for payment within 60 days if insurance has not paid regardless of any insurance company's arbitrary determination of usual and customary rates. If a balance is due and we are not contracted with your insurance company we will balance bill you.

Finance Charges: A finance charge will be imposed on each item of your account which has not been paid within 60 days of the time the item was added to the account. The finance charge will be computed at the rate of (1.5%) per month or an annual percentage rate of 18%. The finance charge on your account is computed by applying the periodic rate (1.5%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed (60) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum finance charge is $.50.

Returned Checks: A $25 per check fee will be charged for any checks returned from the bank or any charge backs from a credit card.

Broken Appointment Fee*: **Our office has a strict no show policy. If you miss three appointments within an 18 month period, you may be dismissed from the practice. Cancellations made within 4 hours of your appointment time are also***

<u>counted as a no-show. We request a 48 hour notice when cancelling or rescheduling appointments.</u> A $50 fee will be charged to your account without a 48 hour notice of cancellation or an appointment that is missed without notice to the practice.

Past Due Accounts: We will take necessary steps to collect your debt. If we have to refer your account to a collection agency, you agree to pay all of the costs which are incurred to collect this debt to include legal fees and court costs.

Divorce: In case of separation or divorce, the party responsible for the account prior to the separation/divorce remains responsible for the account. After a divorce the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree/consent order requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: A request in writing is required to have copies of your records sent to another doctor or organization. There is a $25 fee for a personal copy of your records. You authorize us to include all relevant information, including your payment history.

Use and Disclosure of PHI: You consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Authorization to Assign Benefits to Dentist: By signing this agreement, you are assigning payment of benefits, if any, otherwise payable to you for services directly to Kathryn J. Sudikoff, D.M.D., P.L.L.C. This authorization is valid from this date until written notice of cancellation is received. You understand that you are responsible for all charges not covered or paid by this assignment.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems so that we can assist you in the management of your account. If you have any questions, please contact our office.

Thank you for choosing our office for your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible.

I acknowledge that I have read, understand and will comply with the policies listed above.

Patient Name (s): _____

Responsible Party: (if a minor)_____

(or personal representative)

Signature: _____

Date: _____