Watsontown Dental P.C.
151 Main Street, Watsontown, PA 17777
570-538-5533 www.watsontowndental.com

We are committed to providing you with the best possible care and pleased to discuss our services with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policies or your responsibilities.

INSURANCE ASSIGNMENT AND RELEASE

For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to deal with insurance companies. We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or required to send payments to us.

We make every attempt to assist you in keeping your insurance submissions up-to-date. After each dental visit, an insurance claim will be sent to your insurance company. You may be asked at this time to pay your deductible. When your insurance payment is received at the office and posted to your account, the remaining balance will be billed to the patient. Payment is expected within 30 days regardless of insurance status at this time. It is the patient's responsibility to keep dental claim status current.

We file insurance claims as a service to our patients. Please keep the following in mind:

- Your dental insurance is a contract between you, the insurance company, and your employer. Watsontown Dental has contractual arrangements with several dental insurance companies, but not all.
- Not all dental services are a covered benefit with all insurance plans.
- You, the patient, are ultimately responsible for the TOTAL cost of your dental care.
- If a major procedure is needed, a Pretreatment **estimate** can be sent to your insurance company requesting an **estimate** of services to be completed. When this Pretreatment is received, an appointment can then be scheduled. The patient's estimated balance due is expected at the time of service. If the Pretreatment Estimate is not received by our office before the treatment is completed, we will estimate the patient's portion of cost and payment is expected at that time.
- Our office will honor our fees on treatment plans for six months after the date these fees were quoted to the patient.

There are constant changes being made between your employer and insurance carriers that often change coverage, deductibles, and annual maximums. We are rarely informed when changes occur. It is difficult for us to know exactly what each policy covers. It is the patient's responsibility to know what their insurance covers.

In order for us to maintain our high level of service to you the patient, we provide the courtesy of submitting the claim on your behalf and supporting you with maximizing your benefits. However, we are unable to carry your insurance balance for longer than 60 days. Policy coverage, changes and follow-up on unpaid claims are your responsibility. Please be prepared to show your insurance card at the time of your visit. _______ (**initial**)

I certify that I and/or my dependent(s) are covered by insurance with ____________________________________

(*Please print name of insurance company)*

and assign directly to **WATSONTOWN DENTAL, P.C., Dr. Dale R. Chomas, DMD all** insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. _____________**(initial)**

Watsontown Dental, P.C. may use my minor child's health care information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. _________ (**initial**)

FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made or payments are anticipated from your insurance. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full responsibility for all charges for services or items provided to me or the patient. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges. _________ (**initial**)

PAYMENT OPTIONS

For self-paying patients, a 7% day of service discount will be applied to your bill if paid in full by **cash or check only** on day of service. Your options include cash, check, MasterCard, Visa, Discover, and American Express. We are pleased to offer you a choice of No Interest or Extended Payment Plans to qualified applicants through Care Credit, our financial partner. **Care Credit cards will only be accepted in our office by the person whose name is on the card. ID is required when using the Care Credit card.** If you would like to make extended payments for services provided at our office, please ask one of our administration team for the Care Credit brochure_______ (**initial**)

ADDITIONAL TERMS

Checks returned by your bank are subject to a $45.00 processing charge. After 60 days, if no payment has been made on the account, it will be sent to a third-party collection agency. _________ (**initial**)

CANCELLATION POLICY

When you make an appointment with us, you reserve our time, our facilities and our attention. While we understand that emergencies do occur, if you are unable to keep an appointment, we ask that you kindly provide us with a minimum of two (2) business days' notice. All changes in your scheduled appointment **must** be handled during our regular business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. __________ (**initial**)

To the best of my knowledge, the information on this form is complete and correct. I understand that it is my responsibility to inform the doctor if either I or my minor child ever has a change in health.

____ ______________________

Signature of Patient/Responsible Party *Date*

____ _______________________

Print name of patient, parent, guardian or personal representative *Relationship to patient*