Mary Makhlouf, DMD, MS, PA

OFFICE PAYMENT POLICY

PLEASE READ AND SIGN

PATIENTS WITH DENTAL INSURANCE

The fee for our services is your responsibility. As a convenience to you, we will file your insurance, but we do expect your 20% to 50% estimated patient portion at the time of service. Please note that we will keep your insurance outstanding for 45 days from date of service; after that time you are directly responsible for any balance on your account regardless of insurance issues. All special arrangements regarding finances must be signed by you as the patient/guardian and our clerical staff. Our office accepts cash, check, major credit cards and CareCredit as payment.

If you have another person paying for some or all of your services or balance, please know that they are not privileged to any of your information including account information. We cannot discuss anything with them unless you expressly give us written permission for a specific person. Please make arrangements for that in advance if it applies to you.

PATIENTS WITH NO DENTAL INSURANCE

Payment in full is expected at the time of service. A 3% discount will be applied if paying by check or cash. We do not offer in-house financing. However, we have partnered with CareCredit, which is an outside financing agency, to assist you with payment arrangements. Please see our clerical staff for more information.

ALL PATIENTS: An 18% annual (1.5% monthly) finance charge is applied to balances beyond 90 days.

FILING YOUR INSURANCE CLAIMS

Our office is pleased to offer you the courtesy of filing your insurance claim for you, using the insurance information you provide us. It is however, your responsibility to determine what your insurance will or will not cover and to be aware that we are non-network and will treat you with the honors and privileges that you deserve as an out of network patient. We appreciate the value you put into having your dental team give you more attention and spend more time with you. Please remember that the contract is between you and your insurance company and that you are fully responsible for any amount not paid by your insurance, for whatever reason your insurance gives.

Our office policy regarding insurance payments:

1. The courtesy of accepting your insurance payment may be withdrawn if circumstances warrant, and without notice if necessary. This means you will then need to pay the full fee for the services rendered on the day of the visit.
2. Your insurance is legally obligated to pay within 30 days. If your insurance has not paid within 45 days for whatever excuse it gives, *you* must pay the balance due and seek reimbursement directly from your insurance company.
3. Dr. Makhlouf's responsibility is to submit the proper code based on services rendered and ADA definitions of the codes. Insurance companies sometimes request a change in code. While that is legal for the insurance company to do on their end, it is not ethical to require the dentist to make those changes. We will not change codes.
4. Our office does NOT guarantee payment by your insurance company. We will make every effort to explain and document the indications for treatment or diagnostics provided. However, if for any reason your insurance claim is denied, you are responsible for the full amount of your bill.
5. Our office will NOT enter into a dispute with your insurance company over your claim. This is your responsibility.
6. In the event that your insurance company pays you directly, your obligation is to send us a check for your dental services immediately upon receipt of the insurance check. We are extending this courtesy because it is kinder. However, non-compliance will result in requesting full payment at the time of service.

I have read the above information and will comply with all of the above policies. I certify that I am the patient/guardian of the patient and am authorized to furnish the information requested. I understand that I, not my insurance company, am responsible for decisions regarding any treatment choices and for payment of the services rendered and that Mary Makhlouf, DMD, MS, PA does not participate in any dental plan. I further agree to be solely responsible for any collection costs associated with my account.

SIGNATURE: _____ DATE: _____