F I N A N C I A L P O L I C Y

DENTAL HEALTH OF SILVER SPRING
11 FLOWERS DRIVE, SUITE 100 • MECHANICSBURG, PA 17050
(717) 766-0600 • (717) 766-0668 (fax)

This is an agreement between Dental Health of Silver Spring, a PA Professional Corporation, as creditor, and the Patient/Debtor named 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 Dental Health of Silver Spring. By executing this agreement, you are agreeing to pay for all services that are received.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE:

You are expected to pay by cash, check or credit card on the day treatment is rendered.
For treatment involving laboratory fees (crowns, bridges, dentures, etc.), we expect 50% payment on the preparation date and the balance on the completion or delivery date.
For extensive treatment, you may prefer to secure financing through a bank or credit union for the entire amount and make payments to the lending institution.
We offer special financing through Care Credit. If you pay them within 12 months there is no interest charge.

PAYMENT OPTIONS IF YOU HAVE INSURANCE:

1. You are expected to pay your deductible and any out-of-pocket portions at the time services are rendered by cash, check or credit card. This amount is an estimation which can result in an overpayment or an additional amount due.
2. For extensive treatment (crowns, bridges, dentures, etc.) you are requested to pay 50% of your out-of-pocket portion at the start or preparation date and the balance on the completion or delivery date.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge and any payments or credits applied to your account during the month.

PAYMENTS: The balance on your statement is due and payable when the statement is issued and is past due if not paid by the end of the month.

CHARGES TO ACCOUNT: We retain the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

FINANCE CHARGE: A finance charge will be imposed on each item of your account which has not been paid within sixty (60) days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of one and a half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE of eighteen (18%) percent. The "overdue balance" of your account is calculated by taking the balance owed sixty (60) days ago and then subtracting any payments or credits applied to the account during that time.

PAST DUE ACCOUNTS: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cumberland County, PA.

RETURNED CHECKS: There is a fee (currently $35) for any checks returned by the bank.

CONTRACTED INSURANCE: If we are contracted with your insurance company we must follow our contract and their requirements. It is the insurance company that makes the final determination of your eligibility.

NON-CONTRACTED INSURANCE: Insurance is a contract between you and your insurance company. We are

NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance.

WORKERS COMPENSATION: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

DIVORCE: In the case of divorce or separation, both parents shall remain equally responsible for the account prior to the divorce or separation. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree 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. It is not our responsibility to collect payment from arguing spouses.

MISSED APPOINTMENT FEE: The second time a patient does not show up on time for an appointment, or cancels with less that 24 hours notice, a $55 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another office.

CREDIT HISTORY: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

TRANSFERRING OF RECORDS: When we are requested to transfer your records to another office, you authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorized us to receive all relevant information, including your payment history.

WAIVER OF CONFIDENTIALITY: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record, and you hereby consent thereto.

CO-SIGNATURE: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective to any subsequent charges.

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.

Patient's Name: _____

Responsible Party

(If not the patient): _____

Signature: _____ Date: _____

Signature Update:_____ Date: _____

Signature Update:_____ Date: _____

Signature Update:_____ Date: _____

Signature Update:_____ Date: _____

Signature Update:_____ Date: _____