Hampshire Family Dental Financial Policies

Hampshire Family Dental strives to offer convenient payment options while at the same time maintaining the high standard of comprehensive dental care that our patients deserve. As a courtesy, we are happy to bill your dental plan for services. At the onset of your treatment, we will provide you with an estimate of your total treatment costs. Our goal is to help you afford your dental choices.

Please understand that this will only be an **estimate**. Should the need for additional treatment arise during the course of the original treatment plan, the fees could change. Please take a moment to review the financial options offered for co-pays**. *** All co-payments are due at the time of service.**

- We accept Visa or MasterCard.
- Personal Check/cash.
- We are pleased to offer our patients another monthly payment plan option through a dental financing company called **Care Credit.**

Treatment Estimate and Insurance

Based on the information we receive from you, your insurance carrier, or benefit information we may have on for your employer, we will give you a treatment estimate on what you can anticipate your co-payment to be. **Please understand that these are only estimates**. Hampshire Family Dental does not presume to act as a representative of your insurance carrier. If you have a large treatment plan and would like us to submit a pre-treatment estimate to your insurance please ask us. This is still not a guarantee of benefits but is more accurate. We will not know the benefit amounts available until actual payment from your insurance carrier is received. **All co-payments are due at the time of service. Should your carrier pay less than what was expected, deny the claim, or pay you directly you will be responsible for payment of the balance. X_____**.

Your insurance is a contract between you, your employer and your insurance company. Hence, the insurance company is responsible to you and you are responsible to us. Many times claims will take up to 30 days to be paid to us. If our efforts to collect insurance payment are unsuccessful, you will be asked to assist us in resolving the problem. **If your insurance company has not paid your account in full within 45 days, you will be held responsible for the balance.**

White fillings (bonding)

White fillings on posterior (back) teeth may or may not be covered by your insurance. Some insurance companies may only pay a silver filling benefit which means that you **may have a higher out-of-pocket expense**. The estimate we give you is our best attempt at discerning what they may pay. Whatever the case, you are responsible for payment of the balance. **X_____.**

I, _____, accept full financial responsibility for this account and for all dentistry performed upon my dependent(s) in this dental office. **I understand that it is up to me to confirm my insurance eligibility, waiting periods, and benefits**. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment.

YOUR APPOINTMENT IS CONSIDERED CONFIRMED
WHEN YOU MAKE IT. WE WILL TRY TO REMIND YOU WITH A COURTESY CALL, EMAIL or TEXT 24 HOURS IN ADVANCE. MISSED APPOINTMENTS OR CANCELLATIONS WITH LESS THAN 24 HOURS NOTICE ARE SUBJECT TO A $50 FEE. X_____.

Signature_____ Date_____