



Financial Policy

As a patient of our practice, we are committed to providing you with the highest quality care and the best patient experience; therefore, your clear understanding of our policies, fees and billing process are important to our professional relationship. We are happy to answer any questions you may have about treatment options, fees, policies or your rights and responsibilities.

Please initial next to the statement below that applies to you regarding dental insurance (*only initial one*):

_____ A) If you **DO NOT** have dental insurance on the date of service, payment is due in full on the date services are rendered.

We accept cash, personal checks, major credit cards including Visa, Mastercard, Discover, American Express as well as approved payment plans through CareCredit.

_____ B) If you **DO** have dental insurance on the date of service, we will collect your ESTIMATED co-pay for the services rendered. Prior to your visit, if possible, we will contact your insurance provider to obtain the most accurate and recent information regarding your coverage. Eligibility and benefit details given to us at this time by your insurance provider are only ESTIMATES and ***exact coverage and payment detail cannot be determined until after your claim has been filed and processed by the insurance provider.*** As a courtesy, we will file your insurance claim and as legally required, your insurance provider must process the claim within 30 days. ***Payment by your insurance provider for services rendered is never guaranteed.*** Therefore, after we receive payment or notification of denial by your insurance provider, any balance left on your account will be your responsibility.

Dental insurance is first and foremost a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage and to provide our staff with accurate information to process your claim efficiently (i.e. your dental insurance's group number, member number, employer, etc). It is not our place to enter into disputes between you and your insurance company regarding deductibles, copayments, etc.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as employment changes, changes in policy holder, insurance provider change, or policy termination.

Broken Appointments Policy

We understand that unforeseeable events may occur and require the rescheduling of your appointment. Should such an event occur, please provide our office us at least 24 hours notice (*Monday appointments must be cancelled by Friday at 12pm*). This policy enables us to give your reserved time to another patient on our waiting list for treatment.

Failure to arrive for your scheduled appointment or cancelling your appointment without 24 hours notice will result in the assessment of a \$50.00 fee, (add \$25/30mins for longer scheduled appointments i.e.\$100.00 fee for 2 hour appointment) to your account. *Please note, this fee is not covered by any insurance.*

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Acknowledgement of Privacy Practices

I hereby authorize Brian K. Motz, DDS PC dba Monocacy Valley Dental (MVD) to use and disclose my protected health information (PHI) to carry out payment activities in addition to treatment and health care operations. (I have the right to read the Notice of Privacy Practices prior to signing this consent. MVD reserves the right to revise its Notice of Privacy Practices at any time. I may obtain a revised copy by contacting the office. I have the right to restrict how MVD uses or discloses my PHI for treatment, payment or health care operations. Whenever possible, MVD will honor my request. I also have the right to revoke this consent at any time, in writing, but such revocation will not affect any disclosures already made.

I also understand that I or my account guarantor will be financially responsible for any balances older than 30 days on my account.

Print Name

Relationship to Patient

Signature

Date

I, _____, direct my dental care providers and payers to disclose and release my protected health information and billing information to:

Name

Phone #

Relationship