SMARTDENTAL

SMARTDENTAL LLC - 1045 WHALLEY AVE NEW HAVEN, CT 06515 FAX: (203) 389-6702 - PHONE: (203) 389-6701

FINANCIAL POLICY

Thank you for choosing us to take care of your dental health. Please read carefully our Financial Policy. Our main concern is to provide you with the best possible care to establish and maintain oral health. Therefore, if you have any concerns about our payment policies please do not hesitate to speak with our business staff. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Please be aware that the parent bringing the child to our office is legally responsible for payment of all charges. We cannot send statements to other persons.

Payment Options: Payment is due at the time services are rendered. We accept cash, check, and for your convenience MasterCard, Visa, and Discover.

Assignment of Insurance Benefits: If you like for us to accept assignment directly from you insurance company on your behalf, you will need to agree with the following terms:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment. We will estimate your co-payments as closely as possible based on the insurance information you provide.
3. We will require a current credit card on file and a current Release and Assignment Authorization. Please be assured that your information will be maintained with the utmost confidentiality.
4. When we receive a payment from your insurance company, we will bill you the remaining balance, if any. If we do not receive any payments from you after 30 days we will bill the balance to your credit card. If there is a valid family credit on the account, we will issue a refund. As a courtesy we will call you regarding charges to your credit card account.
5. If your insurance company, either primary or secondary, does not pay your balance in full within 30 days, we ask that you contact the insurance carrier to help speed things along.
6. If we do not receive payment from your insurance company, primary and secondary if applicable, within 45 days of the date of services, the entire fee for that date of service will be charged to your account.
7. If you do not wish to keep your credit card information on file with us, we will then require full payment at the time of service, and we will have your insurance company reimburse you directly.

Balances older than 30 days may be subject to late payment charges of 1 1/2 % per month (18% per year), plus collection costs and attorney fees. Returned checks will be subject to a returned check fee.

Missed appointments: If for any reason you cannot keep a scheduled appointment, please let us know at least 24-72 hours in advance. We reserve the right to charge a $25.00 dollars fee for a broken appointment.

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We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

If you have any questions please feel free to speak with any of our business staff. Again, thank you for choosing us to care for your dental health. We appreciate your trust in us and we appreciate the opportunity to serve you.

I grant my permission to you or your assignee to telephone me at home or at work to discuss matters related to this form.
I have read and received a copy of SmartDental's Financial Policy and agreed to the above conditions of treatment and payment.

Date: _____

_____ _____

Signature of Patient/Responsible Party Print Name

I authorize Smart Dental L.L.C to keep my signature on file and to charge my debit card for the balance of charges not paid by insurance within 45 days and not to exceed the amount of charges incurred to my account in the date of service.

_____ _____

Credit Card Holder: Signature

Account number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

Expiration date: _____

Security code: _____

back of your credit card

Updates:

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