S & K DENTAL SPECIALTY GROUP
258 W. Newton St., Boston, MA 02116

Payment Policy and Patient Responsibility

Thank you for choosing us as your dental health provider. We are committed to providing you with the attention, care and technology necessary to solve your present dental needs as well as to prevent unnecessary dental disease in the future. Please read the following policies, initial each section, and sign below in the space provided. A copy will be provided to you upon your request.

1. **INSURANCE:** Knowing your insurance benefits is your responsibility. We participate with some, but not all insurance companies. If you are not insured by a plan we are contracted with, payment is expected on the day of your visit. Please contact your insurance company with any questions you may have regarding coverage.

   Initials_____

2. **NON-COVERED SERVICES:** Please be aware that some or all of the services provided to you during your visit may not be covered by your insurance company. Any unpaid services are the patient's responsibility and payment may be required in full at the time of the visit.

   Initials_____

3. **PROOF OF INSURANCE:** All patients must complete the patient registration form before receiving any services at our office. We also require a copy of your current insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim in full.

   Initials_____

4. **CLAIM SUBMISSION:** Your insurance benefit is a contract between you and your insurance company. As a courtesy to you, we will submit claims to both primary and secondary insurances. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Any unpaid balances remaining 90 days after claims have been submitted to your insurance company become your responsibility.

   Initials_____

5. **COVERAGE CHANGES:** It is important to notify us as soon as possible of any changes pertaining to your insurance coverage. Failing to do so may result in unpaid claims and you may be responsible for the balance of the claim in full.

   Initials_____

6. **UNINSURED/SELF-PAY PATIENTS:** If you are seeking dental services at our office and do not have insurance, payment in full is expected on the day of your visit. In addition, we offer **Care Credit** to uninsured patients who apply and meet the eligibility guidelines. If you are interested, please speak with our front desk staff.

Initials_____

7. **NONPAYMENT:** If your account is 90 days past due and arrangements have not been made, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless satisfactory arrangements have been made with our billing department. If balances remain unpaid, we will refer your account to a collection agency. In addition, if you pay with a check and your check is returned, your account will be charged a **$25.00 Returned Check Fee.**

Initials_____

8. **MISSED APPOINTMENTS:** We require a 24-hour notice on all appointment cancellations. Our policy is to charge for missed appointments and failure to cancel more than 24 hours in advance may result in a **$75.00** fee, billed directly to you, the patient. The **$75.00** fee must then be paid prior to receiving additional services at our office. If you fail to keep an appointment due to unforeseen circumstances, please discuss with our billing department. After two or more missed or late appointments, your account will be reviewed and you may be released from our practice as a patient.

Initials_____

I have read and fully understand the policies written above.

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Patient Name (Print) **Date**

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Patient or Legally Authorized Representative Signature

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Legally Authorized Representative (Print) **Relationship to Patient**