

Diana T. Brawka, D.D.S., P.C.

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General Dentistry



FINANCIAL POLICY

Thank you for choosing **Diana T. Brawka, D.D.S., P.C.** as your dental health care provider. We are committed to the successful treatment of your dental health. Please understand that payment of your bill is considered successful completion of your treatment. Should you have any questions regarding any aspect of your financial status with our office, please feel free to contact our Office Manager at 630-554-5157.

All Patients

- **FORMS:** All Patients/Responsible Parties must complete our Patient Registration Form and other related treatment forms, including the **PATIENT / RESPONSIBLE PARTY FINANCIAL AGREEMENT** at the conclusion of this Financial Policy.
- **INFORMATION CHANGES:** Notification of any changes in submitted charge card information or insurance status or coverage must be given at time of service and before payment is due.
- **CANCELLED OR MISSED APPOINTMENTS:** If you must cancel a scheduled appointment, please notify the office ASAP BEFORE the scheduled appointment date. While we understand that emergency circumstances can occasionally arise, less than 48 hours notice of cancellation may result in a \$50 Cancellation Charge at our discretion. Failure to give any notice before missing an appointment will result in a mandatory \$75 Missed Appointment Charge.
- **TREATMENT CHARGES:** We are committed to provide the best treatment possible for our Patients, and we charge what is usual and customary considering the expertise and skills of our licensed providers, and the quality and workmanship of our suppliers. If we do have a contract with your insurance company, as a courtesy to you we will submit your insurance claim for reimbursement payable directly to us, but you are responsible for payment of your deductible and co-pay at time of service unless prior arrangements have been approved in writing. Additionally, you may be responsible for payment of the balance of our set charges in full regardless of your insurance company's arbitrary determination of UCR (usual and customary rates). Payment of any balance remaining after insurance reimbursement is due within 30 days.
- **ACCOUNT BALANCES;** All Patients/Responsible Parties are financially responsible for all charges not covered by insurance, and guarantee the balance to be paid by credit card, check or cash. Balances due past 90 days will be subject to additional fees and charges, including a finance charge of 1.5% per month, along with any collection costs incurred, including, but not limited to, agency costs, attorney fees, and court costs.
- **PAYMENT METHOD:** We accept cash, check, Visa/MasterCard, American Express, Discover.
- **RECORD COSTS:** 5 business days advance notice is required for pick-up copies of medical records or x-rays, and there may be a nominal fee.

Self-Pay

- If you are self-pay or we do not have a contract with your insurance company, you are responsible for payment of our set charges in full at the time of service, unless prior arrangements have been approved in writing.

Dental Insurance

- If dental insurance coverage is available, we are happy to bill insurance directly, however, we must have a copy of the insurance card on file. If no insurance card is presented at time of service, full payment may be due when services are provided.
- Payment of deductibles and estimated co-payments are due at the time services are provided. Copays are only an estimate of the difference between total treatment and what the insurance company may cover. We try to accurately estimate copays, however, since they are only an estimate, there may be an additional balance due after insurance payment.
- The Patient/Responsible Party is responsible for verifying that we are providers for the plan in question. Any dispute in insurance coverage is between the Patient/Responsible Party and the insurance provider, and the Patient/Responsibility Party remains the party responsible for full payment to Diana T. Brawka, D.D.S., P.C. of any treatment provided.

Card on File Payment

In an effort to simplify the payment process, we utilize a convenient, highly secure, Credit/Debit/HAS card and Bank ACH Payment Program for our patients.

- Unless all treatment charges are paid in full at time of service, the Patient/Responsible Party is required to provide a credit card on file (card/ACH based) as payment assurance, whether relying on insurance coverage or a payment plan approved in advanced.
- If the Patient/Responsible Party is relying on insurance coverage, co-pays and deductible are due at time of service. As a courtesy we will file a claim with insurance on their behalf, and provide the Patient/Responsible Party with estimated out-of-pocket costs as applicable, typically within 3-5 business days after services have been delivered. After the insurance claim has been processed and payment is received, a bill will issue for Patient payment due within 30 days, including any unpaid co-insurance, co-pays, and deductible as applicable. If payment is not received within 30 days of bill issuance, the credit card on file will be charged for any payment due, and a receipt will be sent.
- If the Patient/Responsible Party is relying on a payment plan approved in advance, the credit card on file will be charged for any payment due under the payment plan which is not timely received.

PATIENT / RESPONSIBLE PARTY FINANCIAL AGREEMENT

I understand and agree that I am financially responsible for all treatment charges for Patient (print name) _____ and I guarantee payment thereof.

In the case of default on payment of this account, I understand and agree to pay 1.5% monthly interest unpaid balances after 90 days, and any reasonable costs of collection services, attorney fees and court costs incurred in attempting to collect on this account and any future outstanding account balances.

I understand and agree that if **Diana T. Brawka, D.D.S., P.C.** bills insurance as a courtesy, I must cooperate as needed to ensure payment for services rendered. I understand that I am the party responsible for payment for all services rendered. If payment is not received from insurance within 90 days of claim submission, I may be billed directly for the entire outstanding balance.

I will pay unpaid balance by: ___Cash ___Check ___Credit Card ___Debit Card

Signature of Patient/Responsible Party

Name of Responsible Party if other than Patient (print)

Date _____

Witness: _____