Nordstrom Family Dental
Wee Care Pediatric Dentistry

PAYMENT FOR SERVICES POLICY

Please read, initial where indicated, and sign below.

INSURANCE BILLING

- Insurance coverage is not a guarantee of payment. (_____ *initial*)
- We will bill your insurance if you present your insurance card(s) at the time of your appointment. It is important for you to understand that <u>you are responsible for monitoring</u> the processes of your claim, and that you are ultimately responsible for payment of services rendered. (_____ *initial*)
- Any co-payments or "patient responsibility" must be paid at the time of service. (_____*initial*)
- **If we do not receive a response from your insurance company within sixty days from the date we bill them, the balance will become your responsibility.** *(_____ initial)*
- You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time. (_____ *initial*)

We also recommend that you research your insurance benefits prior to your office visit, as there could be reasons why your insurance may not pay for your visit. These reasons might include the following:

- Your deductible has not been met.
- The services or procedures are not covered under the plan due to exclusions or frequency limits.

We will inform you when we know a procedure will not be covered, but many times it is not possible for us to know with certainty, as this varies greatly among insurance companies, and because they will not make a final determination until they have received the claim. We will be happy to provide you with an estimate of your fees before treatment is given. You are responsible to pay for the non-covered services at the time of the visit.

The following authorizations are included on all dental claims. Because we submit the claims for you, a 'Signature on File' must be kept in your record. Please sign both authorizations.

AUTHORIZATION TO RELEASE INFORMATION: I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry our payment activities in connection with this claim.

X _____ Date _____
Signed (patient, parent or legal guardian if minor)

AUTHORIZATION TO PAY BENEFITS TO NAMED DENTIST: I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____ Date _____
Signed (patient, parent or legal guardian if minor)

PATIENT RESPONSIBLILTY AND PAYMENT

We accept cash, check, VISA, Mastercard and Discover. If a payment in check form is returned to us because of insufficient funds, you will be charged a $25 fee. Payment ***in full*** at the time of service is required in the following circumstances:

- You do not have insurance coverage.
- You have not provided your insurance information.
- Your insurance benefits have maxed for the year.
- Any procedures we believe are not covered.

By my signature below, I acknowledge that I have read and that I understand the above statements and am willing to accept responsibility to pay for services rendered if my insurance does not cover them. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

_____ _____
Patient Signature (or financial responsible party) Date