prosthodonticsofmadison
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Dental Services Financial Policy

Welcome to Prosthodontics of Madison. Our goal is to provide you with the highest quality care available. We are committed to helping you determine the most appropriate treatment for your dental needs. Should you have questions concerning your treatment, treatment sequence, or fees for our services, please ask for clarification before treatment is started.

OUR FINANCIAL POLICY:

- For regular hygiene visits, oral evaluations, consultations and emergency visits, **full payment is due at the time of service**, regardless of insurance. For patient accepted treatment plans with ongoing periodic visits, proportional **payment is due at the time of service for each stage of treatment**, regardless of insurance.
- We accept the following forms of payment: Cash, Personal Checks, Visa and MasterCard
- Payment plans for certain procedures are offered through *The Lending Club Patient Financing* with 0% interest up to 1 year or low interest payment options available up to 7 years.
- Dental Insurance Benefits – Insurance is a contract between the patient and/or employer and their insurance company. There is no contract or agreement for compensation between our office and any insurance company. Further, because we are not a dental insurance network provider, insurance companies may or may not pay us directly for services provided to our patients. Also, our patients are usually referred from another dentist, and sometimes are then sent by us to a specialist (such as an Oral Surgeon for extractions). As a result, Prosthodontics of Madison has no way of knowing how much coverage remains available on a patient's dental insurance plan. As a courtesy to our patients, we are happy to assist your reimbursement process by filing your insurance claim(s)* and providing any details that the insurance company may require. You may wish to assign benefits to this office as we process your insurance claims for you. *Prosthodontics of Madison is not responsible for denied coverage or slow reimbursements by the insurance company. **Responsibility for payment belongs solely to the patient (or patient's Responsible Party if patient is a minor.)**
- We will provide estimates for our cost of services. Predetermination of benefits with insurance benefit plans may be advisable if there is a question concerning coverage. Nevertheless, preauthorization is not a guarantee of payment from the benefit plan.
- Extended treatment plans (treatment requiring more than one visit) will be outlined so that appropriate payments can be made as each phase of treatment is begun. **Prior to the beginning of treatment, an initial payment for services equal to that of 50% will be collected based on the proposed treatment plan .**

*If we are assigned benefits, your insurance company may still reimburse you directly. It is important for you to take an active role, communicating with your insurance company and with this office regarding reimbursements outstanding or paid to you.

By signing below, I am stating that I understand and agree to the above stated policy. I hereby authorize Prosthodontics of Madison to disclose to insurance companies all information contained in their health care records for the purpose of securing payment of any benefits that may be payable by said insurance companies for services rendered to me by Prosthodontics of Madison. The foregoing consent to disclosure of my health care records shall remain in effect until such time as I deliver a written notice to Prosthodontics of Madison stating that I have revoked their consent to the disclosure of my health care records to my insurance companies.

Regardless of remaining insurance coverage(s), I understand that I am personally responsible for all payments on their account in full at the time services are rendered. I acknowledge that a $25 fee will be assessed to their account for checks written that are returned for NSF (non sufficient funds.) Should it become necessary to refer my account to an agency or attorney for collection, I acknowledge that I will be responsible for costs associated with collection, including any attorney's fees and/or court costs.

Printed Patient Name:_____

Patient Signature:_____ Date:_____

Responsible Party Printed Name:_____

Responsible party Signature:_____ Date: _____