

Karl A. Smith, DDS, LLC

We would like to take this time to thank you for the opportunity you have given us in treating you. Dr. Smith and his staff look forward to serving all your periodontal needs. We have found that a clear understanding of what your dental needs are and the financial responsibility for your care are very important. Our policy is to provide each patient with a written estimate of recommended treatment. Our business staff will provide you with *estimated costs* of your treatment and benefits; however, we do encourage all patients to familiarize themselves with their insurance policies.

OFFICE AND FINANCIAL POLICIES

1. Karl A. Smith, DDS, LLC requires that each patient complete our patient verification forms.
2. Karl A. Smith, DDS, LLC expects that **all** patient co-payments are due at the time services are scheduled. We do offer outside financing for extensive treatment. Financing is subject to approval by a participating financial group. For your convenience, we accept Cash, Personal Checks, MasterCard, Visa, American Express, and Debit Cards.
3. All patients having an existing account balance that are past due **will not** be rendered service until balance has been justified. All future treatment will be placed on hold until balance is paid in full. Any patient who has not paid the amount due past 30 days would be subject to a 1.5% monthly finance charge. **If it becomes necessary to refer your account to collection agency, in addition to your account balance, you will be responsible for collection fee of 42% of the balance due. If it becomes necessary to refer your account to an attorney, in addition to your account balance, you will be responsible for attorney fees of 40% of the total balance due which includes previous collection fees.**
4. Karl A. Smith, DDS, LLC reserves the right to charge a thirty dollar fee for returned checks.
5. Karl A. Smith, DDS, LLC reserves the right to obtain credit reports on patients when necessary. This would only be for financing treatment.
6. Any patient who defaults on a payment arrangement by 10 days beyond the contractual date will be expected to pay the balance in full immediately.
7. Karl A. Smith, DDS, LLC reserves the right to charge for broken and cancelled appointments in accordance with our office policy.
8. Karl A. Smith, DDS, LLC does not extend courtesy discounts to anyone unless pre-approved by Dr. Smith in advance of treatment.
9. All patients, under the age of eighteen, **must** be accompanied by parent or guardian who must remain on site while treatment is rendered to minor.
10. **All insurance claims not paid within 45 days of submission to the insurance company are due payable by the patient.**
11. For all services, deposits are due upon scheduling of your appointment. **DEPOSITS ARE NON-REFUNDABLE ON BROKEN APPOINTMENTS.**
12. Patients using 3rd party financing will be charged a processing fee of 9.9% of the total financed amount should they decide to not complete treatment with our office.

INSURANCE POLICIES

1. Dental benefits are based on a contract **between your company's insurance administrator and the individual participating in the plan.**
2. Karl A. Smith, DDS, LLC is not responsible for obtaining your benefit information. We obtain an **ESTIMATE** of benefits on the patient's behalf. **Should you receive a non-covered service; full fees will be charged.**
3. **It is your responsibility to be familiar with restrictions, limitations and deductions that may apply to your plan.**
4. All deductible or co-payment amounts must be satisfied when scheduling your appointment. The requested amount of co-payment is estimated on the information received from your insurance company. All claims that are rejected or adjusted by the insurance company will become your additional responsibility and payable to Karl A. Smith, DDS, LLC immediately.
5. Patients who have insurance companies of which Karl A. Smith, DDS, LLC is not a participant, will be expected to pay the full amount of treatment upon scheduling. We will provide you with a statement of service to submit to your insurance carrier once balance is paid in full.
6. **PLEASE NOTE:** We have opted out of **MEDICARE** and are **NOT IN NETWORK. YOU ARE RESPONSIBLE FOR FILING CLAIMS TO MEDICARE.**

COORDINATION OF BENEFITS

1. Karl A. Smith, DDS, LLC will submit only to your primary insurance company, using the primary guarantor and birthday policies. We will gladly provide you with a statement of service to submit to your secondary insurance company.
2. Patients with two primary insurance plans must choose **one** plan to use for the entire year. You will not be permitted to change plans back & forth during the year.

PLEASE PRINT NAME _____

SIGNATURE OF PATIENT

DATE

SIGNATURE OF PARENT OR GUARDIAN

DATE