Office Payment and Patient Accounts Policy

We are committed to providing you with the best possible dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our payment policy.

PFD has participating contracts for several dental insurances and can submit to any out-of-network policy on your behalf. Check with your insurance prior to your appointment to verify if Dr. Pohl is a participating provider.

Payment Policy & Methods:

For the convenience of our patients, we offer the following methods of payment:

A. **Payment** in full by cash, check, bank card or alternative financing for each appointment as service is rendered. A 5% courtesy is offered on all payments over $300.00 when paid in full by cash/check at the initial appointment for *non-insured patients only*.
B. **Insured Patients**: we will accept payment of the initial examination directly from the insurance company for the percentage the company will cover. We gladly accept insurance assignments but **require** that the deductible, estimated patient portion and any non-covered fees be paid at each visit. In the event of duplicate payment, you will be reimbursed. No discounts will be given.
C. **Bank charge cards** – Visa, MasterCard, Discover are accepted.
D. **CareCredit** is available in our office. A business office team member will be able to assist you in filling out an application. Credit approval is required.
E. **Checks** are an acceptable form of payment if proper identification is provided. Any account with a check returned for insufficient funds will be charged
F. **Major services**: All major dental services require payment in full on the initial appointment date. For prosthesis, payment in full is due at the initial appointment or with an office courtesy of ½ payment at the initial appointment and ½ at the completion.
G. **Basic services**: Fillings, crowns, periodontal tx, extractions, etc. payment in full is due on the day of the service.

Parents/Guardians:

- Any parent/guardian bringing a child to our office is legally responsible for payment of all services rendered.
- Only one person is permitted to accompany a patient into the dental operatory space for their appointment. If a parent/guardian chooses to stay in the waiting area during a procedure, the dentist, hygienist, or dental assistant will have you come to the procedure room if desired after the procedure is completed.
- **Any patient under the age of 18 must be accompanied by a parent/guardian for every appointment.**
- In the case of divorce or separation, the parent/guardian accompanying the minor will be responsible for payment.

It is important that you realize that…

- Your dental program is a contract between you, your employer, and the insurance company. We are not a party to that contract. This office files to your insurance as a courtesy to you.
- Not all dental services are a covered benefit in all contracts.
- You (not the insurance company) are responsible to us for the total of fees for services rendered to you.
- For patients with insurance, **an estimate** will be given of the benefits that the insurance company is expected to pay, and any co-payment is expected at the time services are rendered.

ACCOUNTS

- Any account with a standing balance due may be turned over to a collection agency or small claims court. We make every effort to provide you with exceptional service and expect our patients to provide payment for those services, when necessary.
- Any patient account with a credit over $25.00, with no future treatment scheduled, will be issued a credit refund to the patient or guarantor at the address on file.

I authorize Putnam Family Dental to bill my dental insurance(s) and assign all benefits otherwise payable to me.
I acknowledge that I have read and understood the above policy regarding me or my dependents patient account:

_____	_____	_____/_____/_____	Signer is: ❑ Self
Patient/Guardian's Signature	Print Patient/Guardian's Name	Date	❑ Parent ❑ Guardian