

Financial Policy

Thank you for choosing us as your dental provider. We are committed to your dental treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any dental treatment. All patients must complete our information and insurance form (if applicable) prior to seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF TREATMENT OF COMPLETED SERVICES. WE ACCEPT CASH, CHECK, DEBIT, MONEY ORDER, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. WE DO OFFER EXTENDED PAYMENT ARRANGEMENTS THROUGH CAPITAL ONE, IF NEEDED.

Regarding Insurance

Currently, we participate with only Delta Premier insurance company. Some insurance companies allow assignment of benefits. An example of one insurance company which does not allow assignment of benefits is United Concordia. In this case, you pay us at the time of treatment and the insurance company pays the patient directly. If your company does allow assignment of benefits, you will be billed for the balance after payment has been paid by the insurance company. More extensive services may require deposits and payment as treatment progresses. Please be aware, that some and perhaps all of the services provided may be non-covered services under your insurance policy.

Usual and Customary Rates (UCR)

Our practice is committed to providing the best treatment for our patients and we charge what we believe is a fair fee. You are responsible regardless of any insurance company's arbitrary determination of the usual and customary rates.

New Patients

For new patients, we are requesting that a minimum down payment of \$100 be issued on the first visit. If patient does not have insurance, the full amount of services rendered that day is required. If patient does have insurance, it will be submitted and once payment received, reimbursement of any funds will be sent to the patient.

Credit Card Information

Our office has been experiencing problems with timely payments of co-pays, deductibles and personal payments. Therefore, we have implemented a new policy regarding unpaid account balances. Please know that it is not meant to offend our patients.

If applicable, after we have received your insurance payment, we will bill you for any non-covered service, deductible, co-insurance or remaining balances. If we have not received your payment within 30 days of the initial billing date, the credit card presented will automatically be charged for your full balance.

I understand and agree to the above method of payment and authorize the office of Dr. Dorothy A. Rooney, D.M.D. to charge the balance of my account to the credit card presented.

_____ Date _____

Signature

_____ Visa _____ MasterCard _____ Discover _____ American Express

Credit Card Number

_____ Expiration Date

_____ 3 Digit Security Code

X _____ Date _____

Signature of Patient or Responsible Party

X _____

Witness