East Endodontic
DENTAL SPECIALISTS

FINANCIAL POLICY
(PLEASE READ AND SIGN)

We feel that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

- **Patients without Dental Insurance:** Payment is due at time of service. Upon the completion of treatment, payment is expected to be paid in full. Financial Coordinator will go over the estimated treatment total at the time of initial visit.

- **Patients with Dental Insurance:**
  - **Our doctors are participants with the following insurance:**
    - **Dr. Joubert:** Aetna, Ameritas (check your plan), Careington Dental, Cigna, Delta Dental, Dental Savings Plans, EDP, Empire Blue Cross Blue Shield(Prime & Complete, and Premium Care Network), GEHA-Connection Dental Network, Guardian, and Metlife, United Healthcare (commercial plan only)
    - **Dr. Sanchez**: Aetna, Ameritas (check your plan), Careington Dental, Cigna, CSEA, Delta Dental, Dental Savings Plans, EDP, Empire Blue Cross Blue Shield (Prime & Complete, and Premium Care Network), GEHA-Connection Dental Network, Guardian, and Metlife, United Healthcare (commercial plan only)
  - Patients are responsible for deductibles, co-insurance, co-payments, patient responsibility charges, and any service that is not covered by the patient's insurance plan.
  - While we **do not participate** with every insurance plan, as a courtesy, we will file an insurance claim for you and you will be reimbursed directly from the insurance company (known as "assignment of benefit").
  - If your insurance pays **more** than the estimated amount, a refund check from this office will be mailed within 1 month from the date payment is received in this office.

- For your convenience, we accept cash, personal checks, and Visa, Master Card, American Express, and Discover, as well as bank debit cards & Care Credit.

- In certain cases, we can make arrangements for a third party lending service to arrange a comfortable amount to be automatically billed to you each month. Please see the financial coordinator to discuss this option. Please note this is contingent upon credit approval.

- ANY appointments that are **CANCELLED** less than 24 hours prior to the scheduled appointment, or if the patient is not present within a reasonable time of the scheduled appointment, will be subject to a $50 no show fee.

I acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of treatment, unless other specific arrangements are made with the office prior to treatment. I assign my insurance benefits to East Endodontic Dental Specialists. I am fully responsibly for all charges if my insurance company does not agree to pay. If payment is not received within 120 days of the date of the first statement recorded on file, a collection agency will be notified to collect any debt that is owed to the doctors. All collections debt will be subject to a 33% surcharge. In addition, I am responsible for all deductibles, co-insurance, co-payments, and any service that is not covered by my insurance plan. I authorize the release of any information relating to dental treatment to my insurance company.

I have read and understand this information. I understand that my insurance company may deny coverage and request that East Endodontic Dental Specialists perform all dental services anyway. I agree to be personally and fully responsible for all charges. I understand that the providers named above are relying on this understanding and are rendering services based on this promise. I hereby authorize payment of dental benefits, otherwise payable to me, directly to East Endodontic Dental Specialists.

To acknowledge your understanding of our policy, please sign and date below.

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Signature of patient, Parent/Guardian | Relationship to Patient | Date
(If patient is under the age of 18, the signature of a parent or guardian is required.)

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Print Full Name