Mary-Stuart Gallian, DMD ***

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Financial – 2022

We are happy to have you as a patient and look forward to offering you and your family the finest dental care available. We strive to provide high quality care for our patients, in a pleasant and comfortable atmosphere. Please understand that payment of your bill is considered part of your treatment. We ask that you **CAREFULLY READ** this financial policy before you sign it.

Patients Who Self Pay
If you do not have insurance or if we do not participate with your insurance company, you are responsible for 100% of the payment when services are rendered.

Patients with Dental Insurance:
We must emphasize that, as your dental care provider, our relationship is with you and not your insurance company. It is your responsibility to check and see if we are in/out of network with your insurance before your appointment. As a courtesy to you, our office will file your claim with your insurance company. However, you are the sole responsible party for all charges incurred and you guarantee payment. From our experience, few insurance plans cover the complete cost involved and benefit eligibility obtained from your insurance company is not a guarantee of payment. Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. Coverage issues can only be addressed by your employer or group plan administrator. *We cannot act as a mediator with the carrier or your employer.*

You are expected to understand your benefits coverage and responsibilities. We are willing to help to the best of our abilities but there are restrictions on what we can access for your insurance plan. We do not guarantee payment of your claim or accept responsibility of negotiating your claim. If we have requested information from you that is needed to complete a claim with your insurance company and have not received the information in a timely manner, you may end up responsible for the full amount if insurance declines to make payment due to time allotted. We can only file up to two insurances. If you have three or more insurance plans, you will have to file to the third, etc. if you choose to do so.

To use your insurance benefits, you are responsible for providing us with correct insurance information and the identification number, group number, and mailing address of your insurance company.

- All co-pays and deductibles are due when service is rendered.
- There will be a minimum $400 down payment required at the time of service for any dental procedure that requires the service of a laboratory (crowns, bridges, dentures, etc). Should any over payment occur, a refund will be issued to you.
- If an account is overdue or unpaid for 60 days, it will be turned over to collections. You agree to reimburse us of any fees of any collection agency, which is based on a percentage at a maximum of 35% of the debt, and all costs, and expenses, including reasonable attorneys' fees we incur in such collection efforts.
- If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and reimbursed when your insurance company pays. After 90 days the

patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist you in your inquiry.

Patients with Out of Network Insurance Plans:
If we are **out of network** with your insurance plan then payment in full is due once services are rendered. We will then courtesy file the claim for you so that you can received your refund check according to your policy. If you also have secondary insurance while being out of network, you are responsible for providing us with a copy of the primary EOB (Explanation of Benefits) so that we can courtesy submit to your secondary insurance.

Patients with Blue Cross Blue Shield:
If you have a secondary insurance to your Blue Cross Blue Shield plan, you are responsible for providing us with the copy of the EOB (Explanation of Benefits) that gets sent to you from them if it is a plan we are out of network with, as the check and EOB gets sent to the patient, not the provider. This EOB is needed in order to file to your secondary insurance for payment from them. If we do not receive the EOB in a timely manner, this may result in not filing with your secondary insurance in the allotted time allowed and will then result in the patient responsible for the full amount billed to insurance. Some insurances require filing within 90 days of treatment.

Missed or Broken Appointments:
We, here at Dr. Mary-Stuart Gallian, DMD, are truly blessed with wonderful patients. We fully understand that life can be unpredictable and things can come up unexpectedly. However, please understand that your appointment time is reserved specifically for you. If you need to break an appointment, we request that you notify us at least 24 hours ahead. **There will be a $50 broken appointment fee (per appointment block reserved for you) for any appointment canceled with less than 24 hours' notice! Note, appointment blocks are one hour, so if you have a restorative appointment lasting longer than one hour, the broken appointment fee will increase.**

Payments and Financing:
We accept personal checks, Visa, Discover, Mastercard, American Express, CareCredit and LendingPoint as payment. Monthly billing statements are sent to inform you of your current account status. Returned check fees are $35 and are billed to your account. *Due to Covid-19 we are not currently accepting cash as payment.* Our office will no longer offer payment agreements with patients. We now offer financing options via LendingPoint upon request.

I have read, understand and agree to the above terms and conditions stated in this Financial Policy. I understand that I am responsible for all fees/or balances due and agree to pay them in a timely manner. I, the undersigned (patient or legally responsible party) hereby authorize treatment to be rendered and assume all financial responsibilities.

X_____ Date: _____

Signature of Patient/Guarantor

X_____ Date: _____

Printed Name of Patient/Guarantor