LANSDALE DENTAL, P.C.
OFFICE / FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful.

All patients must sign this form, complete our medical/dental history, and insurance information forms before seeing the doctor. Full payment, including deductibles/co pays, is expected as services are rendered unless prior financial arrangements have been made. For your convenience, we accept Cash, Check (with valid driver's license), Visa/Mastercard, Discover, and American Express.

Regarding Insurance

Although, we make a good faith effort to determine your insurance coverage, it is impossible to fully determine your exact benefits that you have chosen to purchase through your employer or self employment. Therefore, you are responsible for any balance that your insurance does not pay for. Your co-pay that is given to you at time of service may differ to those determined by your insurance company when claim(s) is/are processed. For exact pricing, please contact your insurance company. Any portion of the bill not paid by the insurance company is your responsibility. We may (or may not) accept your insurance benefits. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all of the services provided may be non-covered services under your insurance plan. In the event your insurance denies payment of a claim, you are responsible for the full payment of the services rendered.

PAYMENTS/COPAYS/DEDUCTIBLES DUE AT TIME OF SERVICE

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge fees that are usual and customary for our area. You are responsible for payment regardless of any insurance company/s arbitrary determination of usual and customary rates.

Minor Patients

All minors must be accompanied by a parent or legal guardian at the time of treatment. The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For the unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan. Visa/Mastercard, Discover, American Express, or payments by cash or check at the time services are rendered.

Fees

Our fees are based on treatment received and have no bearing on outcome. The patient is responsible for all collections and attorney's fees. This office reserves the right to add a monthly financial charge of 1.5% on unpaid balances after 30 days, $20 for records transfer, and $25 for any returned check.

EMERGENCY EXAM AND X-RAY FEE: $65 AFTER OFFICE HOURS FEE: $75
CREDIT APPROVAL OF RESPONSIBLE PARTY REQUIRED FOR PAYMENT PLAN OPTION

Missed Appointment

Unless cancelled at least 24 hours in advance or in emergency situations, our policy is to charge for missed appointments at the rate of $25 per fifteen minutes of scheduled time. After the 3rd "No-Show" (cancellation without 24 hours notice), or indiscriminate cancellation Lansdale Dental, P.C. reserves the right to demand transfer of patient's records, through written notice, within 30 days to another dental office of the patient's choosing. During this period of record transfer, only emergency coverage will be provided for a 30 day period. Please help us to serve you better by keeping your scheduled appointments.

Thank you for understanding our Office/Financial Policy. Please let us know if you have any further questions or concerns.

I have read, understand, and agree with the terms and conditions of this Office/Financial Policy.

Signature of Patient or Responsible Party_____Date_____

Signature of Co-Responsible Party_____Date_____