**RAYMOND J. STEINER, D.D.S.** **Specialist in Periodontics**

4550 Lake Street
Lake Charles, LA 70605

Telephone: (337) 478-1000
Fax: (337) 478-7200

**Office Hours, Emergency Care and Appointments:** Our office hours are 8:00AM to 5:00PM Monday through Thursday and 8:00AM to 12:00PM on Friday. Should an emergency situation arise, please contact us as early in the day as possible so we can schedule your appointment in a timely manner. If you must change your appointment, we request a 24-hour notice so that the time reserved for you can be given to another patient. A $100.00 broken appointment fee may be charged to patients with confirmed appointments who fail to keep their appointments or who do not give 24 hour notice of cancellation. If there is a pattern of repeated missed appointments, the appointments you missed will be reviewed and determination made whether we can continue to provide you with dental care.

**Fees and Payments:** We expect all new patient examinations and diagnostic x-rays to be paid for at the time of service regardless of insurance coverage. At the time of the initial examination, you will be given a treatment estimate and payment options will be reviewed with you. All treatment is to be paid for at the time of service. Payment options are:

1. Cash or check – A 5% cash discount is given when treatment is paid in full at time of service.
2. MasterCard/Visa/Discover
3. Interest Free Monthly Payment Plans available, with prior approval, through CareCredit Applications available through our office, and on our website (under new patient registration).

Overdue balances (balances older than 90 days) will be charged a 1.5% per month (18% per year) late charge. A $25.00 charge will be assessed on all checks not honored by the bank (e.g.NSF).

**Dental/Medical Insurance:** We will help you receive the maximum benefits available from your insurance plan, but please remember that no insurance plan attempts to cover all dental costs. Each insurance company has its own deductibles, limitations of benefits, yearly maximums and usual and customary fee determinations. Some companies prorate dental benefits while others pay only a maximum limit regardless of disease severity. Remember that your treatment plan is based upon your treatment needs and not based on a contract between the insurance company and your employer. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance company. Our policies regarding insurance are:

1. We will file your insurance claims electronically for you. Initial exam visits are filed informing your insurance company that you have paid the visit, and they reimburse you. Pre-treatment estimates are filed once a treatment plan has been determined. Estimates often take 4 to 6 weeks for your insurance company to process.
2. If a written estimate (predetermination) is available at time of service, you are required to pay your co-payment (the amount your insurance company does not pay).
3. If a written estimate (predetermination) is not available and you wish to begin treatment rather than wait, you are required to pay treatment fees in full at time of service and your insurance company reimburses you. See Fees and Payments for a list of your payment options.

**Collection Disclosure Statement:** The primary responsibility of this office is to help patients experience the best in periodontal care and to spend time and energy toward that end. In the interest of good business practice, it is desirable to establish a collection policy to avoid any misunderstandings. Therefore, the following points must be clarified:

I ______________________ understand and agree that I am responsible for **ALL** fees regardless of insurance coverage.

I understand and agree that in the event my account becomes delinquent (payments not received within 90 days of their due date) my account will be turned over to an agent or attorney for collection. If collection action becomes necessary, I agree to pay all collection, legal and court costs in addition to the unpaid balance.

I HEREBY CERTIFY, THAT I HAVE READ AND RECEIVED A COPY OF THE AFOREGOING DISCLOSURE STATEMENT AND ARE IN AGREEMENT WITH THIS __________ DAY OF ___________, 20______.

Signature____________________________________Witness_______________________________