CHIPS DENTAL ASSOCIATES
FINANCIAL POLICY

Thank you for choosing Chips Dental Associates, LLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of this is making the cost of optimal care as easy and manageable for our patients as possible.

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand that the agreement regarding your dental benefits is between you, your employer (if applicable) and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your company to make payment directly to our practice.
- You must pay the **estimated** copayment, which is the amount not covered by your insurance company, at the time we provide service to you. The copayment is only an estimate of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments are ordinarily received within 30-60 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we may ask you to pay the entire balance at that time. You will then be responsible for seeking reimbursement from your insurance company. You have the option of being directly reimbursed from your insurance company. If you choose to do so, all fees will be due at the time of service.
- Our practice does not guarantee that your insurance company will pay for the treatment that you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our practice will not enter into a dispute with your insurance company over any claim, although we will provide the documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to know the services covered by your insurance and to resolve any disputes over payments made or not made by your insurance company to our practice.

In the event that you do not have dental insurance, you have the option of joining our Dental Club, which is not insurance coverage, but rather, a discount program on dental services which we provide for you. The following applies to those patients without insurance:

- We accept payment in thirds for comprehensive treatment plans of over $1000. A 50% deposit is required to secure your initial treatment appointment.

Payment options include cash, check, Visa, Mastercard, American Express or Discover Card. We also accept payment through CareCredit (subject to credit approval) on amounts over $200, which features 12 months no interest financing and convenient, low monthly payment plans if paid within the promotional period. Otherwise, interest is assessed from purchase date.

Chips Dental Associates reserves the right to charge $75 for cancellations of less than 48 hours or for failure to appear for a scheduled appointment without notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient/Parent/Guardian Signature: _____ Date: _____

Patient Name (please print): _____