PATIENT PAYMENT AGREEMENT

A. **Payment in full is due at the time of service.** We cannot grant exemptions. We offer a 10% discount for accounts *paid in full at time of service* with cash or check. Insurance, credit and debit card transactions are ineligible for this discount.

B. **Insurance**: As a courtesy to you, we will file your insurance claim. It is your responsibility to know the limits of your insurance as we cannot guarantee what your insurance will pay. We will estimate as closely as possible what your out of pocket expenses will be. If your insurance provider denies a claim, *you may indeed be responsible for covering the costs* associated with that claim. When an insurance claim is denied, it's typically for reasons such as the claim not meeting the terms of your policy, lack of coverage, or other specific exclusions outlined in the policy. In such cases, it's important to review your insurance policy documents carefully to understand why the claim was denied. If you believe the denial is unjust or incorrect, you can usually appeal the decision through your insurance company's appeals process. This may involve providing additional information or documentation to support your claim. If the denial stands even after an appeal, you may need to cover the costs out of pocket or explore other options for assistance, such as seeking legal advice or negotiating with the parties involved. It's crucial to understand the terms and conditions of your insurance policy and to communicate effectively with your insurance provider to address any issues or concerns regarding claim denials. **You will be expected to make payment at the time of service for any deductibles or copayments for your treatment.**

C. **Delta Dental:** Delta Dental requests that as *Out of Network* providers, we collect payment **day of service** and they will reimburse you directly via check. **The policyholder is responsible for the balance difference.** As a courtesy we will file your claim and they will send you a check directly within 14 business days.

D. We offer interest free or payment plans through **CareCredit** dental financing. You may apply online at www.carecredit.com. If approved, print off the approval with your account number and bring it to your appointment.

E. In case of divorce or separation, **the parent accompanying the child and authorizing treatment will be the parent responsible for the charges on the day of service.** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

700 South Ham Lane
Lodi, CA 95242

ACKNOWLEDGEMENT

I, ____________________________, authorize treatment for myself or minor, and agree to pay
Print First, Last Name
all fees and charges for such treatment.

I understand that I am responsible for payment of any unpaid balance due from my insurance company within 60 days of treatment.

I understand that overdue accounts will be sent to a collections agency and I authorize release of protected information for collections purposes. I also agree to pay the collections agency fees.

I understand that there is an interest penalty of 1.5% per month on any outstanding balance over 60 days.

There will be a service charge on all returned checks.

I acknowledge receipt of a copy of this agreement.

____
Patient/Responsible Party Signature

____
Date