

**IRWIN C. MISHOULAM, D.D.S.  
FINANCIAL POLICY**

*We appreciate you as a patient and thank you in advance for your cooperation in complying with our policy.  
We accept Cash, Check, VISA, MasterCard, Discover, American Express, Chase and CareCredit.*

**NEW PATIENTS AND EMERGENCIES**

For patients without insurance coverage, we expect payment in full at the time of the first visit.

For patients with insurance, we require the **estimated** co-payment of the total charge to be paid at the time services are rendered. Once payment has been received from the insurance company, any credit will be issued to you in the form of a check, and any money due us will be billed to your credit card of choice.

All new emergency patients must pay in full at the time of service.

**BILLING FOR NON INSURANCE ACCOUNTS**

We require payment at the time of service.

A 5% courtesy will be given on treatment over \$1000 that is paid in full on the day of service by cash or check.

A **finance charge** is imposed on charges not paid in full within 30 days of the date of treatment. The finance charge is 1.5% per month or 18% per year.

**BILLING FOR INSURANCE ACCOUNTS**

We will **estimate** your insurance co-payment at the time of your visit and require payment of that amount at the time services are rendered.

Filing insurance claims is a courtesy that we extend to our patients. We will file a claim twice as a courtesy within 45 days. All charges are your responsibility from the date services are rendered. If after 45 days from filing your claims we have not received payment from your insurance carrier, you will be billed the remaining balance and asked to discuss your claim with the insurance company.

A **finance charge** is imposed on charges not paid in full (including unpaid insurance) within 30 days of the date of your treatment. The finance charge is 1.5% per month or 18% per year.

**Additional Policy information**

-USUAL AND CUSTOMARY RATE (UCR): Our practice is committed to providing the best treatment possible for our patients. You are responsible for paying the balance in full, regardless of your insurance company's determination of *usual and customary* rates charged in the area.

-SPECIAL PAYMENT PLANS: For patients who wish to extend payments we offer a two 3<sup>rd</sup> party billing plans for 3, 6, or 12 month interest free financing. There is also an extended low interest plan available.

-DIVORCES: The parent who requests treatment for a child is responsible for all debts incurred in our office. If a dispute over payment arises, it is the responsibility of this parent to resolve this issue according to the divorce decree.

-APPOINTMENT FAILURES AND CANCELLATIONS: *A fee may be charged for missed appointments and cancellations within 48 hours of your appointment time.*

I have read, understand and agree to the above policy. I understand that I am fully responsible for the fees for service rendered, regardless of any insurance I may have.

Signature of Account Holder \_\_\_\_\_

Date \_\_\_\_\_

**INSURANCE BILLING POLICY (If applicable)**

We are anxious to help you receive your maximum allowable benefits from your dental insurance. As your dental care provider, we feel it is important that you understand that our relationship is with you, not your insurance carrier.

We are happy to process your insurance claims. If your dental insurance carrier or coverage should change, please provide our office with your updated information. By keeping us updated with your plan you help us control expensive delays in payment.

1. **Your insurance is a contract between you, your employer and your insurance carrier. We are not a party to that contract.**
2. We will submit your claims electronically or directly into MetLife's web site the day services are performed. We will resubmit the claim one more time within a 60-day period. If we are not paid by your insurance company 60 days after treatment, you will be billed the total amount and any interest that has accrued after 30 days, and you are expected to pay for these services within 10 days. If we received a check from your insurance company, a refund will be forwarded to you.
3. Patients with coverage from BlueCross BlueShield of California, or any other insurance carrier that does not reimburse our office directly will be required to pay their bill on the day of service.
4. Although your policy may state you have 100 percent coverage on either preventive or basic services, be aware that your annual deductible may still apply and the 100% figure may be for an arbitrary amount set by the insurance company or your employer.
5. Any information our office gives you regarding your insurance coverage is an **estimate**. We make these estimates based on information available to us. We are not responsible for any decisions regarding payments that the insurance carrier makes.
6. Our office is not responsible for monitoring the amount of annual benefits used. Please check with your insurance carrier to determine the remaining benefits for the current year.

I have read, understand and agree to the above office policy. I understand that I am fully responsible for the fees for services rendered, regardless of any insurance I may have.

Signature \_\_\_\_\_

Date \_\_\_\_\_

