RANDAZZO DENTISTRY

FINANCIAL POLICY Please read, initial each financial policy line, and Sign at the Bottom of the Form

Welcome to Randazzo Dentistry and thank you for selecting our practice. We are committed to providing you with the best possible care. If you have dental insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our policy.

_____ (Initial) **Your dental insurance is a contract between you and the insurance company. It is your responsibility to understand the benefits of your plan for any and all services.** We do not routinely check your dental insurance benefits. We cannot guarantee payment of your claims that we file. We file as a courtesy to you and your insurance company will not give us a guarantee of coverage. If your insurance company pays only a portion of your claim or rejects your claim, you and/or the policyholder should make an inquiry to your insurance company. Payment delays or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. Unfortunately, delays in reimbursement may make you subject to: a $75 late fee for balances older than 30 days plus a 10% administrative fee, and a $75 fee for returned checks.

_____ (Initial) We participate in a number of dental insurance plans. All patients are required to pay their co pay, co-insurance, deductibles, and any patient balances owed at the time of their visit. Patients that do not pay their co-pay in full at time of visit will be charged an additional $25.00 administrative fee unless payment arrangements have been made. All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered" for any reason, you will be responsible for the entire charge for all services rendered. We will attempt to verify benefits for some services; however you remain responsible for charges for any service rendered. Patients are encouraged to contact their insurance company for clarification of benefits prior to services rendered. In the event you do not satisfy your financial responsibilities, the practice will use a collection agency, and will provide protected health information to that agency. If such agency is used, you will be responsible for a 35% balance based collection fee and any additional costs related to satisfying that debt, including, but not limited to, court costs, and/ or reasonable attorney fees that may be incurred in the collection of an outstanding balance affiliated with satisfying your financial responsibility.

_____ (Initial) Missed appointments: You will be billed a $75.00 charge for missed appointments not cancelled with at least 72 hours notice.

_____ (Initial) If you believe your insurance company has made an error or not adequately addressed your claims you may contact your insurance company and/or file a grievance or appeal with the Virginia Bureau of Insurance at the State Corporation Commission at 1-877-310 -6560.

I, _____have read and I understand the above financial policies. These policies are subject to change without prior written confirmation.

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Signature of patient or legal representative Date