FORT WAYNE ENDODONTICS, P.C.

Financial Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time.

If you have dental insurance, we will do all we can to maximize your benefit. Dental Insurance is a contract between you, your employer, and your insurance carrier. Your dental insurance is not a contract between your insurance carrier and your doctor, unless your doctor is a provider for your insurance carrier and has contracted to a specific fee schedule with your carrier. The estimated payment for the primary policy will be due at the time of service.

The reimbursement levels will vary from one insurance carrier to another. One carrier may say they pay 80% for root canal treatment (endodontics), when what they actually pay is 80% of the carrier's fee schedule, which is usually below the actual fees for our geographic area. Insurance companies determine benefit packages and payment rates ("usual and customary" or UCR) by the plan type that is purchased by the employer/insured party – not by the level of care provided by our office. All charges, including interest, accrued from the date of services rendered, are your responsibility regardless of insurance benefits, arbitrary determination of UCR payment, or lack thereof. Factors such as deductibles, annual limits, and maximum allowable amounts per procedure may also cause differences in reimbursement.

On treatment visits, we are usually able to accept your insurance if you obtain prior approval from our office. We will have you pay your estimated portion not covered by insurance (we will determine for you). If your insurance pays more than your account balance, we will send you a refund immediately.

No procedure performed on the human body can be guaranteed, as such payment is due and fees are non-refundable regardless of treatment outcome.

As a courtesy our office will file, at no cost to you, your insurance claim with your carrier at the time of service. You must provide us with accurate and complete information to properly obtain the maximum reimbursement. We will provide your carrier copies of x-rays and/or written narration on your claim should your carrier require this level of documentation. We are willing to wait up to 60 days from the date of service for payment from your carrier. After ninety (90) days, unpaid accounts will go to collections. It is therefore very important that you take an active role in following your claim with your insurance carrier.

Should your insurance company (specifically, Delta Dental) send payments on your behalf directly to you after service, we will require 100% of the fees payable for the services rendered that day.

NON-INSURED PATIENTS: All fees are payable on the day services are rendered.

We value your busy schedule and strive to see patients at their scheduled appointment times; we ask you to extend the same courtesy. Whenever possible please provide a minimum of 48 hours advance notice when requesting a scheduling change so that we can arrange care for our other patients experiencing urgent endodontic needs.

Please circle your method of payment: Check Cash Visa MasterCard Discover Care Credit

Financial Agreement: I have read, understand, and agree to the financial policy set forth by Fort Wayne Endodontics, P.C. I understand that this office has not contracted with any insurance company and will file my insurance as a courtesy. I understand that insurance benefits given at the time of service are only estimates and that I am responsible for the payment of this account. I understand that as soon as my insurance carrier issues a payment, or after 60 days, any unpaid portion of my claim will be due. I authorize my insurance carrier to issue benefits directly to this office and also release any information necessary to process the dental insurance. If the use of a third party becomes necessary to secure payment, I agree to be responsible for any and all collection charges incurred, which includes 35% of my outstanding balance and cost of collections, which includes court costs and attorney fees.

Patient (guardian)_____ **Date**_____