Beville Dental Care
Family & Cosmetic Dentistry

FINANCIAL POLICY

Thank you for choosing **Dr. Nitish Mathew D.M.D.,** as your dental care provider. We are committed to the success of your treatment. The services provided by our office are services you have elected to receive which imply a financial responsibility on your part.

SELF PAY: If you do not have dental insurance, payment is due in full at the time of service.

INSURANCE: We work & are contracted with many insurance plans, but please understand that we can only estimate insurance benefits, **knowing your insurance benefits is your responsibility.** In most instances actual insurance payments vary. Please note that all insurances have a disclaimer stating that information given over the phone or by predetermination **is not a guarantee of payment.**

COPAYMENTS AND DEDUCTIBLE: **All co-payments and deductibles must be paid in full on or before the time of service**. This arrangement is part of your contract with your insurance company.

NON COVERED SERVICES: Please be aware that some services you receive may not be covered or not considered by your insurance carrier. **You are responsible for these services in full.**

CLAIM SUBMISSION: As a courtesy to you, we will submit your insurance claims for the services rendered in our office and assist you in any way reasonably we can to help get your claims paid. If your insurance company needs information from you, it is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility, whether insurance pays or not. Your insurance benefit is a contract between you and your insurance company.**

- ***PATIENT BILLING:*** **You will be sent up to two statements for your financial responsibility after your insurance has processed claims. After the 2nd notice your account MAY be forwarded to a Collection Agency. If this occurs, you will be assessed an additional fee of 40% of the amount turned over. Please let us know if you have difficulties in resolving your bill. Payment arrangements may be considered on a case by case basis. Initial _____**

PAYMENT POLICY: **All balances are due in full on or before the time of your office visit whether or not you have received a statement from our office.** We will provide you with a copy of your bill and insurance credits upon request. **There is a $35.00 charge for checks returned unpaid by your bank.** We accept all major credit cards, debit cards, and offer 3rd party financing through Care Credit and Lending Club.

OFFICE CANCELLATION POLICY:
48 hrs advance notice is required to reschedule or cancel an appointment; in the event that proper notice is not given, Dr Nitish Mathew's reserves the right to charge $100 per missed visit. Any broken appointment fees must be paid prior to rescheduling the appointment.

We ask all of our patients to sign below to acknowledge that they have read and understand our financial policy. For our patients with insurance, their signature will also authorize their insurance carrier to send payment directly to *Dr. Nitish Mathew*. You may refuse to sign this acknowledgment of our policy**. In refusing, we may not be allowed to file insurance claims on your behalf and payment of services rendered will be collected on or before the time of service in the form of cash or accepted credit/debit cards only.**

PRINT Patient Name:_____

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Signature of Patient or Responsible Party ***Date***