Lehigh Valley Smile Designs
Financial Policy 2023-2024

INSURANCE: We are out of network with your **medical insurance,** but certain dental procedures may be reimbursed direct to you by your medical plan. Present your card and ask for details.

2023 Dental PPO Network Participation: UCCI. Most plans and participation may be subject to change at any time in 2023.

Insurance and Reimbursements:

- **A credit or debit card on file is required for us to file a courtesy insurance claim on your behalf and wait for payment (accept assignment) from your dental insurance plan. INITIAL HERE:**
- **Please give your medical insurance ID, dental insurance card, and a credit or debit card to the Patient Coordinator at the Front Desk.**

You are 100% responsible for all fees for all services that you or your dependents receive at this office.
INITIAL HERE:

If you prefer not to leave a payment method on file, then you may pay in full at the time of service, and file for direct reimbursement from your insurance company.

- **If you elect to have our office file a dental insurance claim on your behalf, then you give permission for the following:** Outstanding patient responsibility as determined for any reason by your plan, and all other outstanding balances, will be charged to the payment method on file: if applicable this will happen on the same day the EOB is posted to your account. If our guesstimate of your patient responsibility was high, the card on file will be credited the difference. **INITIAL HERE:**

Receipts for HSA/HRA/FSA are available upon request.

You will be notified by your insurance company of outstanding EOB balance. Call our office with any questions.

Secondary insurance may be filed as a courtesy at our discretion. Payment will be remitted directly to you by your plan, if applicable. **INITIAL HERE:**

Methods of payment:

- **Cash/Check – Credit Cards (Visa/MasterCard).**
- **3rd Party financing for your dental treatment. Low or No down payment. Payment of applicable 3rd party funding fee may be required.**
- **LVSD Dental Care Payment Plan: No Interest. 50% down payment prior to start of service. Two additional payments will be charged to the payment method on file within 60 days.**

KLEER MEMBERSHIP: Kleer membership is active only so long as dues are current. See contract details.

NOTICES:

- **NO REFUNDS, as all dental procedures are custom services.**
- **RESERVATION FEE is required for all Restorative appointments. It will be applied toward treatment if the appointment is kept as scheduled, or cancelled with 2-business day's prior notice.**

(cont'd on reverse →)

- **Bounced Check Fee (NSF): $50.00**
- **Billing Fee: 1.5% fee per month (18% per year) will be added to unpaid account balances every 30 days.**
- **NO-SHOW / SAME-DAY CALL TO CANCEL: A cancellation fee will be charged to the payment method on file, or the Reservation Fee will be forfeited. Cancellation fees differ according to the Provider that was scheduled. Cancellation Fees (by provider): $75.00 for cancellation with a hygienist; $200 for cancellation with a dentist* (*except re-care exams.)**
- **You are 100% responsible for all fees for services rendered, regardless of insurance, and all EOB and all other account balances will be charged to the payment method on file.**

Agreement by Signature: My written, verbal, or implied consent to pay for treatment is binding when I allow treatment to be performed. I agree to pay all billing fees, collection agency fees, and attorney fees which may result when my account is overdue. I consent to payment transactions by telephone, virtual terminal, payment method on file, or text to pay, to satisfy outstanding account balances and I acknowledge that I understand and agree to the financial policy of this office and have had all my questions answered satisfactorily and give consent to collect payment for procedures received by myself, or by those for whom I am the Responsible Party. I have had full opportunity to read and consider the contents of this entire document. I give my permission for the use and disclosure of my protected health information to carry out treatment, payment activities, collection activities, and healthcare operations.

I understand my full financial responsibility for all service, even if my insurance plan refuses to pay the estimated benefit for service(s), which was provided to me as a courtesy only.

Remember: You are 100% responsible for all fees for services received, regardless of insurance, and all EOB and all other balances will be charged to the payment method on file.

PRINT NAME: ________________________________

SIGNATURE: __________________________________ **DATE:** ________________

WITNESS: ___________________________________

Attestation: This agreement is being signed by the Adult Patient or their Legally Responsible Parent or Guardian.

Consent to Obtain Patient Medication History

To the extent permitted by applicable law, I authorize this dental practice (or thier designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/HIV, and medicines used to treat mental health issues.

Signature: ________________________________ Date: ______________________