EXCEPTIONAL NEEDS DENTAL SERVICES FINANCIAL AGREEMENT

It is our desire to make dental treatment available and affordable to all patients with exceptional needs. To ensure we can maintain our high quality of service and keep our fees as low as possible, it is important that our patients and their families understand any financial responsibilities prior to treatment. Please review the following policies and procedures:

PAYMENT POLICY

Payment is due upon receipt of statement following each mobile visit from one of our providers. Private dental insurance will be billed for our patients as a courtesy and a statement will be sent after insurance has been billed.

1. We accept cash, personal checks, and money orders.
2. Fees will apply for any checks that are returned by the bank.

DENTAL INSURANCE

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

1. You must provide us with an insurance card and/or all of the information necessary to verify your coverage and file your claim.
2. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you; not your insurance company.
3. You are responsible to pay our fees; not what your insurance company allows or considers "usual, customary and reasonable" (UCR), all of which vary from one company to another. **Universally the house/extended care facility call (D9410) fee IS NOT COVERED BY INSURANCE PLANS; THIS WILL BE THE PATIENTS RESPONSIBILITY**.
4. Although we may estimate your insurance benefits, we are not responsible for their accuracy. Knowledge of your benefits is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay.
5. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. **Not all services we provide are covered benefits**. Benefits differ from one company to another.
6. Treatment provided in another dental office during your current plan year may alter your co-payment due for services rendered by our providers. In such cases we are not able to track whether or not you have reached your yearly maximum benefits. Please call your insurance company if this applies to you.
7. There are many factors in determining patient responsibility where coordination of benefits between two insurance companies is involved. We CANNOT guarantee what the out of pocket expense will be.
8. Please understand that our responsibility is to provide you with treatment that best meets your needs, not to try to match your care to insurance plan limitations.

TELE-DENTISTRY opt-in

- ☐ I agree to receive treatment via tele-dentistry when appropriate. Tele-dentistry consists of fee-for-service treatment including remote patient monitoring and consultation over devices such as phones, tablets, or personal computers.

Patient Name:____ Date of Birth:________________

FINANCIALLY RESPONSIBLE PARTY:

Name:____ Phone:_____________________

Billing Address: ____

I have read and understand this document in its entirety; outlining the financial policies of Exceptional Needs Dental Services and agree to these terms.

Signature of patient or parent/guardian: __________________________________ Date:________________