MIDTOWN Dental MIAMI
3915 Biscayne Boulevard, Suite 306, Miami, Florida 33137

Patient Financial Policy Agreement

Thank you for selecting John A. Nelson DDS PA (dba Midtown Dental) for your dental care services. We are committed to providing the highest quality of care. As a courtesy to you, if applicable, we will bill your insurance company for any services rendered. You have been/will be given a Treatment Plan Estimate detailing your estimated patient co-pays for any/all prescribed dental work. Insurance remittance estimates are provided as a courtesy and are based on current information collected from insurance carriers. While we would like to advise you of your exact financial obligation before your date(s) of service, the scale of different insurance plan designs make it extremely difficult. Your co-payment or patient portion may vary based on actual payments made by your insurance provider. Claims for your dental care are submitted on the day treatment is completed. In the event your insurance carrier remits less than the estimated amount of the claim, for any reason inclusive of denied claims, the patient/responsible party, is financially responsible to pay the unpaid balance. Bills for any amount due will be sent to you upon receipt of remittance or explanation of benefits by your insurance company. Payment is due within 30 business days from the date the bill is mailed. If payment is not received by the noted due date, it will be considered PAST DUE and may be sent to collections. Any questions or arrangements pertaining to your bill must be addressed within this 30 day period to keep this account in our office.

Midtown Dental is committed to providing the highest quality care services to our patients. In return, I agree to be financially responsible for payment of Midtown Dental's services. Initial:_____

I agree to give Midtown Dental complete and accurate insurance information for any primary/secondary insurance coverages. I understand that failure to supply complete and accurate information may result in denial of my claim or delay of insurance remittance. I understand that Midtown Dental has the right to close any unpaid claim that is older than 60 days from the date of service. I agree to pay any balance remaining on my account after my insurance claim(s) are processed.

Initial:_____

I understand my financial responsibilities as they may relate to my dental insurance plan, and understand that any insurance portion(s) not paid by my insurance company(ies) are my financial responsibility. In the event of self-pay patients, non-insurance based treatment, I understand that I will be given a detailed treatment and fee estimate prior to any dental work being performed. I understand that I will be 100% financially responsible for the cost of such treatment.

Initial:_____

Patient Financial Policy Agreement Con't

I acknowledge that dentistry is not an exact science and changes in treatment may become necessary during the course of my care. I understand that I will be kept informed of any necessary changes and acknowledge that I will be financially responsible for any such changes.

Initial:_____

I understand that any invoice or receipt issued by Midtown Dental is a non-binding estimate only, and additional charges may apply depending upon actual amounts remitted by my insurance company for services rendered. I agree to pay any balance remaining on my account within 30 days upon receipt of a statement requesting payment.

Initial:_____

Please acknowledge your understanding of this notice and your willingness to comply with the above

Patient:_____ Date:_____

Patient/guardian signature:_____

Midtown Dental Office Policy

Signature: I certify that I, _____ , (or my dependent) have dental insurance coverage and assign directly to John A. Nelson DDS PA all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. Patients without dental insurance coverage understand that they are responsible for 100% of the fees on or before the day of treatment.

Billing Policy: As a courtesy, we will bill your insurance company for services rendered. Once payment is received from the insurance company, you will receive ONE patient statement for the balance due. It is expected that your payment will be made in 30 (thirty) days. If your payment is not received, it will be considered past due and may be sent to collections. We reserve the right to impose a service charge of 2 % per month (18% per annum) on the unpaid balance on all accounts exceeding 30 days, unless previously written financial arrangements have been made. If an account is turned over to a collection agency and/or attorney for collection, the account holder will be responsible for all attorney and/or collection fees. Any balance that is ninety days (90) past due is subject to being sent for collection.

Unpaid Insurance Benefits: understand that all dental services furnished, whether the patient has insurance or not, are charged directly to the patient and that he or she is personally responsible for payment of all dental services. If an insurance company has not paid a claim after sixty days (60) of it being submitted, the office will require that the patient pay the account in full. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. A photo id is now required with all insurance cards. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

Treatment estimates: The office routinely provides our patients with an estimate of cost for prescribed treatment. Since your insurance determines the benefits payable for services the office cannot be held responsible for 100% accuracy on any estimate for treatment.

Alternate benefits: I understand that most insurance companies downgrade coverage on non-metal **restorations and I agree to the adjusted fees for upgraded materials**

Condition of treatment: As a condition of treatment by this office, financial arrangements must be made in advance, and financial responsibility (whether insurance remittance or patient portion) on the part of each patient is determined before treatment. All emergency dental services, or any dental service performed without financial arrangements, must be paid in full at the time services are performed.

Midtown Dental Office Policy

Missed or Broken Appointments: Rescheduling an appointment may be done up to 24 hours prior to your scheduled appointment without expense. If recurring cancellations occur without a 24 hour notice you will be assessed a $50.00 fee per occurrence. The practice reserves the right to dismiss patients due to repeated rescheduling or missed appointments. John A. Nelson DDS PA reserves the right to update this Office Policy at any time without notification. My signature verifies that I have read, understood, and accepted the policies described above, and further grant you or your assignee permission to telephone me at home or at my work to discuss matters related to this form.

Patient:_____ Date:_____

Patient/guardian signature:_____