Olivia Lares, D.D.S. – Berwyn Dental Connection

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Office and Financial Policies

Initial _____ **Insurance:** When making an appointment with our office, it is your responsibility **to know your plan**. As a service to you, we will bill your insurance company. Although we provide this service it is extremely difficult for us and the doctor, to be aware of the multitude of individual requirements for each of these plans. Each plan has its own stipulations regarding the coverage of, and payment for, dental services; therefore, **it is your responsibility to know your plan benefit policies prior to your appointment.** In order for us to bill your insurance, we must have a current copy of your dental card along with all required information. If this is not provided at the time of your appointment, you can reschedule or pay in full at the time of service. We allow 30 days for your insurance to respond on a claim, and 60 days for them to process and/or issue payment. If your insurance does not respond or pay your claim within the 60 days, the full payment will become the **patient/guarantor's responsibility**.

Initial _____ **Deductibles:** Deductibles are due at Check-out. It is your responsibility to know if you have a deductible with your insurance.

Initial _____ **Check-In:** We do our best to keep on schedule, so please arrive for your appointment on time. If you arrive more than 15 minutes past your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced. Please bring your current insurance card with you to your appointment. Without the insurance card, we will be unable to file your insurance, and you will be responsible for the charges of the day. On follow up visits you will be asked to verify demographic and insurance information so that our records remain up-to-date.

Initial _____ **Check-Out:** Please be prepared to pay any past balances on your account. Payment of deductibles and non-covered services will be required at the time of service. For your convenience, we take cash, check, credit cards and Care Credit.

Initial _____ **Non-Covered Services:** If you are coming in for a non-covered service, please be prepared to pay for the services in full at the time of service. Cosmetic procedures ARE NOT covered by insurances and claims will not be filed for them. Most cosmetic services must be paid for by **Check, Cash or Credit.** Cosmetic procedures include but are not limited to: Veneers, Bleaching, etc.

Initial _____ **Dental Emergencies:** I understand that I am responsible for all charges incurred. If my insurance policy determines/denies my procedure as **NOT DENTALLY NECESSARY**, I am responsible for payment in FULL.

Initial _____ **No Shows & Late Cancellations:** We REQUIRE **48 hours (2 days)** advance notice if you must cancel your appointment.

For your convenience, we offer a courtesy Reminder/Confirmation service that will Call, Text or Email to remind you before your appointment. Any NO CALL/NO SHOWS will result in a **$50 fee that will be charged to your account**.

Initial _____ **Credit Card on file:** All patients have the option to keep a credit card on file and signed authorization to charge the credit card once a patient's balance is due. **However, consistently delinquent accounts will be required to keep a credit card on file or pay for services in full at the time they are rendered.**

Initial _____ **Minor:** The parent(s) or guardian(s) must accompany a minor for the first visit to our office. The parent(s) or guardian(s) are responsible for providing current insurance information for the minor and/or payment in full for services provided.

I have read, understand and agree to the above Office and Financial Policies. I hereby attest that I have given and agree to provide demographic and insurance information. I also authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name (PRINT): _____ Date: _____

Signature of Patients (or) Responsible Party
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