Welcome to Cambridge Family Dentistry.

OFFICE PAYMENT POLICY

If you do not have dental insurance, payment in full is due at the time services are rendered. We accept cash, check, money order, Care Credit, and all credit cards (Master Card, Visa, American Express and Discover).

If you have insurance, we require 20% down for basic services and 50% down for major services on the day services are rendered/started. We do not require a "co-pay" for cleaning and check-up appointments.

Insurance

It is the patient's responsibility to provide the office with current insurance information. Our relationship is with you, not your insurance company. Your insurance policy is a contract between you, the insurance company, and your employer. We are not a party to that contract. It is also your responsibility to know your policy and what it covers. Kansas law states that clean insurance claims should be paid within 30 days from receipt (K.S.A. 40-2442). Please call your insurance company if your bill is not paid promptly. Once insurance pays or the claim is closed we will give you 90 days to pay before action is taken on your account. Finance charges will apply to accounts not paid in full within 60 days. You will be charged a fee of $45.00 for returned checks.

Methods of payment

1. **FULL PAYMENT:** On cases of $300.00 or more, a discount of 5% will be given if paid in full with Cash or Check on your first visit. The discount does not apply with Credit Card or debit payments. This does not apply if any other discounts are given, to include contractual write-off's with Blue Cross Blue Shield and Delta Dental.

2. **CREDIT PAYMENTS:** A line of credit is available with Care Credit. Please ask front desk for more information.

All of our Dentists are contracting providers for: Blue Cross Blue Shield of Kansas **(Not the PPO)** and Delta Premier. We file all insurances except Medicaid and it is your responsibility to know what your coverage is with an in vs. out of network provider.

Please be aware that if you have two insurance carriers, you may only get coverage from the Primary carrier due to "non-duplication clause" or "Coordination of Benefits". Again you need to be familiar with your plan's coverage.

Any estimates provided by the staff at Cambridge Family Dentistry are considered as a guideline until final payment is received and the patient's account is reconciled. Cambridge Family Dentistry cannot guarantee payment from your insurance carrier. Pre-determinations are not a guarantee of payment until the claim is processed. Major restorative work cannot be filed with insurance until it is inserted in the mouth about 2 weeks from start of work (on the seat date). Please consider this when doing major restorative treatment.

We cannot bill your insurance company unless you give us all the information needed to submit the claim. Regardless of the insurance company's determination of usual and customary rates or amount of assignment, you are required to pay the full amount charged. Except if we are contracting with your insurance company and they will tell us what the provider write-off will be. Our practice is committed to providing the best treatment possible for our patients, and we charge what is usual and customary for this area. Please be aware that some, and perhaps all, of the services provided may be "non-covered" services and not considered reasonable and necessary under your particular insurance plan. You may be required to sign a waiver for Blue Cross Blue Shield. If at any time you have a question or concern about any treatment, fees, or services please discuss it with us promptly and openly. We would greatly appreciate this and will strive to make your relationship with us a pleasant one. We do charge a $35.00 fee for failed appointments.

I understand and agree that, (regardless of my insurance status) I am ultimately responsible for the balance on my account for the professional services rendered. **I have read all the information on this sheet and have completed my patient registration card with all needed information.** I certify this information is true and correct to the best of my knowledge. I will notify the office of any changes in my health status, insurance, and patient registration information as soon as possible. By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I also authorize payment directly to Cambridge Family Dentistry by my insurance co. We know that service to our patients is at its best when there is complete understanding and mutual cooperation.

Signature: _____ Date: _____