



OFFICE AND FINANCIAL POLICY

Thank you for choosing Kari Mann DDS PLLC as your dental care provider. Our office is committed to providing you with the highest quality dental care. We strive for transparency in our policies in order to better assist you in navigating the financial portion of your dental care. Please understand that payment of your bill is considered as part of your treatment. ***Please discuss available options with our staff to find the solution that is best for you.***

DENTAL INSURANCE BENEFITS:

Our practice is committed to providing the highest quality dental care for our patients. It is our responsibility to provide you treatment that best meets your needs, not to try and match your care to your insurance plan and its limitations. Dental Insurance is different from medical insurance and often falls short of covering the costs of your dental treatment needs. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. We recognize that understanding your dental plan and its limitations can be confusing. Our team will do our best to assist you in understanding your plan and maximizing the benefits you have available. We will not recommend treatment based solely on your limited insurance coverage as this can result in treatment that falls below the current standard of care.

If you wish for us to bill your insurance as a courtesy, on your behalf, your complete insurance information must be presented prior to services being provided. Insurance claims cannot be backdated. By providing this information and signing this document you agree to have Kari Mann DDS PLLC submit insurance claims on your behalf.

Your insurance policy is a contract between you and your insurance company. We are not privy to that contract. As a ***courtesy*** to our patients we can assist you in interpreting your dental insurance benefits to the best of our abilities. We cannot make any guarantees on accuracy or comprehensiveness of the information we are provided. ***You are ultimately responsible to know your plan coverage, exclusions and limitations.*** You should familiarize yourself with the rollover/renewal date for your plan, non-covered benefits and limitations including but not limited to following examples: missing teeth clause, crown/bridge/denture restorations, bruxism, downgraded limitations for fillings and crowns, and frequency limitations for procedures. Our team will do our best to answer any questions you may have, but your insurance member services is the best resource to assist you in fully understanding your plan benefits.

You will be provided a treatment plan estimate for restorative services, this is only an **estimate** based on our best information. It is possible that treatment needs may change in the course of treatment. We deliver the highest quality of care at the most reasonable cost to our patients; therefore payment is due at the time services are rendered unless other arrangements have been made in advance.

PAST DUE AMOUNTS AND FINANCE CHARGES:

All returned checks are subject to a \$35 fee. All balances over 60 days are subject to compound interest in the amount of 1.5% per month. We reserve the right to apply a \$25 rebilling fee and a \$25 late charge, for any overdue payments. Any accounts over 90 days past due will be turned over to a collection agency or attorney, you will be responsible and agree to pay all fees including but not limited to attorney fees, court costs and collection agency fees.

Initial _____
Page 1 of 2



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FAILED APPOINTMENT FEE:

Your appointment is time that Dr. Mann and our team has specially reserved for you. We consider the time set aside for your appointment to be yours alone and important for your health. For this reason we never double book our schedule or accept drop-ins, except in emergencies. **We require 48 BUSINESS hours notice to change or reschedule an appointment.** Exceptions to this policy will be made on a case by case basis depending on individual circumstances. We charge a fee of **\$75 per hour** of the appointment time scheduled for all appointments missed or canceled without 48 business hours notice. Please call us immediately once you realize that you require a change in schedule.

DEPOSITS:

Certain services we provide require special preparation and/or extended appointment times. For these services we do require a deposit to reserve a time on our schedule for these procedures. This deposit will go towards the cost your treatment on the day services are rendered provided your appointment time is maintained or proper notice is given to move or change this appointment. In the event that the reserved appointment time is **missed or moved without 48 business hours notice**, your missed/failed appointment fee will be taken out of the deposit, with exception to individual circumstances on a case-by-case basis.

APPOINTMENT AND OFFICE NOTIFICATIONS:

Our team does our best to communicate with our patients through phone, text and email. Through these services you will also receive confirmations and reminders. You do have the option to opt out of these communications but we do not recommend it. Doing so will remove you from ALL notifications and you will miss important information our office sends out including any confirmations and/or reminders about your appointments. Please note all calls are recorded.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY. ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I AGREE TO ABIDE BY THIS FINANCIAL POLICY.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____