

SOME THINGS YOU SHOULD KNOW ABOUT DENTAL BENEFITS

We believe that you deserve the best care. That's why we present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of folks. Some have dental benefits, but most don't. If you have dental benefits, congratulations! You are very fortunate. If you don't, we have numerous ways to make any type of dental care affordable for you. Here are some important things you should know if you do have dental benefits...

Your dental benefits are based upon a contract made between your employer and an employee benefits company. If you have any questions regarding your dental benefits please contact your employer or the benefits carrier directly.

Dental benefits differ greatly from medical benefits. In 1959, most dental benefit plans had a yearly maximum cap of \$1,000. You'll be surprised to know that today the average dental benefit plan has a yearly maximum cap of \$1,000. There has been no significant increase in the yearly maximum cap in 50 years! However, there have been significant increases in your premiums. Dental benefit plans will never pay for completion of your dental care. It has always been meant to assist you.

Many people receive notification from their insurance company that dental fees are "above usual and customary." A dental benefits company determines their reimbursement level by surveying a geographical area, calculating the average fee, then determines that 80% of the average fee is customary. Included in this survey are discount dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that dental benefit companies define as "higher than usual and customary."

Dental benefit companies do not cover many routine and newer dental services.

Our team members will gladly assist you in filing your claim to maximize your dental benefits and discuss your financial options. Excellent dental care is available with or without dental benefits. We hope you will choose the best that dentistry has to offer.

Payment Options

Patient Name: _____

Responsible Party: _____

Date: _____

Total Treatment Estimate: ~ _____ – Insurance Estimate: _____ Portion Payment: _____
(Treatment List Attached)

1. Payment in Advance:

We are happy to offer a **7%** reduction when payment is made **at least 1-week prior to treatment**.

\$ _____
Discount

\$ _____
Adjusted Total

Must Be Paid By:

Date: _____

2. Payment at Each Visit:

We can offer a **5%** reduction when payment is made in cash **at treatment appointment**. This offer is not available with use of a credit card or if patient is covered by insurance. (Fee is already reduced in these instances).

\$ _____
Discount

\$ _____
Adjusted Total

3. Three Equal Monthly Payments:

One-third of the patient's portion of treatment fee must be paid initially. The next month, another third is paid, and the remaining third (remaining balance) is paid the next month. The remaining balance must be guaranteed with a major credit card.

\$ _____
Payment at 1st appointment

\$ _____
Month 2 payment

\$ _____
Month 3 payment

4. Outside Financing:

Total Treatment Fee is budgeted through **Care Credit** or **Citi Health Card**.

- "Same as Cash" Interest-Free Credit Line Monthly Payments (up to 12 months) interest free
- Extended Payment Plan: 18-60 months duration. No down payment. No pre-payment penalty

5. "Lay-Away" Plan:

Treatment commences after comfortable monthly payments are made which equal the estimated patient portion.

I have read and understand the information above and have checked my choice of payment plans. I understand that any insurance estimate is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office.

Patient Signature: _____

Approved By: _____

These fees are valid for 90 days.

Benjamin D. Bushnell, D.D.S.

Douglas A. Morehouse, D.D.S.

FINANCIAL RESPONSIBILITY

Thank you for choosing our office for your dental needs. Dental treatment is an excellent investment in an individual's medical and psychological well-being. Financial considerations should not be an obstacle to obtaining this important, life enhancing care. We are always available to answer your questions and/or assist you in any way we can.

All dental services, including emergencies, must be paid in full at the time services are performed unless other arrangements are made.

For our patients with dental insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the carrier and the patient. As such, **we can make no guarantee of estimated coverage or payment.** However, please know that we will do everything possible to see that you receive the full benefits of your policy.

Please be advised that **any remaining balance after insurance has paid will be your responsibility and you will be expected to pay this estimated balance at the time services are performed.** You are ultimately responsible for all charges incurred for dentistry performed upon yourself or your dependents in this dental office. This office cannot render services on the assumption that our charges will be paid by an insurance company. Any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

I authorize Benjamin D. Bushnell D.D.S. to perform dental procedures on me, my minor children and / or family members. I understand that dental procedures may vary from planned treatment at the decision of the dentist, according to his knowledge or judgment, in order to provide the highest quality of care in the best interest of the patient.

I hereby authorize the release of any information, including any diagnostic records (x-rays, photographs, charting) to my insurance company. I authorize my insurance company to pay directly to Benjamin D. Bushnell D.D.S. any proceeds payable under the terms of my insurance policy. I understand that I am responsible for my dental bills and the balance on my account regardless of my insurance coverage. I understand that I may incur an 18% finance charge if my balance goes beyond 30 days. I understand that I may incur a \$25 charge on returned checks. I understand, in the event that my account is turned over to an outside collection agency that I am responsible for all fees incurred by Benjamin D. Bushnell D.D.S., P.C. as a result of non payment on my account. I hereby authorize the use of the telephone numbers that I have provided for clinical and collective purposes. I have read and understand the financial policy statement provided to me by office staff.

CANCELLATION POLICY

We respect the importance of your time and work very hard to schedule appointments which accommodate the needs of all our patients. In return, we ask that patients make every effort not to change reserved dental appointments. Broken and missed appointments create scheduling problems for other patients as well as the practice.

If emergency circumstances prevent you from keeping an appointment we certainly understand, all we ask is that you call us immediately so we can try to accommodate another patient. We ask you to provide us with a minimum of twenty-four hours notice. Failure to do so may result in a cancellation/missed appointment fee.

We provide as a courtesy, reminder cards that are mailed for dental hygiene appointments. We also make reminder calls to our patients the day prior to an appointment. This effort shows our commitment to all of our patients and the importance of their health.

I have read and fully understand the above office policies regarding payments and cancellations and accept the terms as they were presented to me.

Print Name _____

Date _____

Signature _____