

Holly Springs Family Dentistry

Meredith D. Taylor, DDS, PA



**190 Rosewood Centre Dr. Suite 200
Holly Springs, NC 27540
(919) 290-2772
FAX (919) 290-2773**

Financial Policy

This is an agreement between Meredith D. Taylor, DDS, PA as a creditor, and the Patient/ Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word account means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Meredith D. Taylor, DDS, PA.

By executing this statement, you are agreeing to pay for all services that are received.

Payment options if you have no insurance:

- 1-You choose to pay by cash, check or credit card(Visa or Mastercard) on the day that treatment is rendered. We do not accept checks for initial visits.
- 2-On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you agree to pay 75% on the preparation date and the balance on the completion or delivery date.
- 3-On extensive treatment, you may prefer to secure a bank, credit union, or other third party financing for the entire amount and make payments to the lending institution.
- 4-We offer special financing through Care Credit.

Payment options if you have insurance:

- 1-You choose to pay your deductible amount and any out of pocket portions (co-pays) at the time services are rendered by cash, check, or credit card(Visa or Mastercard).
- 2-You choose to pay all of your treatment by cash, check, or credit card(Visa or Mastercard). We will request your insurance carrier send their payment directly to you.
- 3- On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you agree to pay 75% of your out of pocket portion on the preparation date and the balance on the completion or delivery date
- 4-We must be given adequate time to verify dental insurance coverage. If adequate time is not available, or if it is a time other than normal business hours when insurance companies are closed. The patient will be treated as though they do not have dental insurance and the options listed as having no insurance apply.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any and any payments or credits applied to your account during the month.

Payments: Unless other arrangements are approved by us in writing, the balance of your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

"Family Dentistry For Your Smile, With A Smile."

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that prior to the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, we will try to submit one for you as a courtesy, however, you are ultimately responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, we will try to submit one for you as a courtesy, however, you are ultimately responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty days of the time the item was added to your account. The Finance Charge will be computed at the rate of 1.5% per month or an annual percentage rate of 18%. The finance charge on your account is computed by applying the periodic rate of 1.5% to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty days ago, and subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is \$5.00.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned Checks: There is a fee of \$30 for any checks returned by the bank.

Missed Appointment Fee: Patients who do not show up on time for an appointment, or cancel with less than 24 hours notice will be charged a \$35 fee per appointment per patient. Missed or broken appointments for larger than one hour of chair time require 48 hours notice for cancellation, and the fee may be higher. This fee must be paid before the new appointment is scheduled. Patients with three missed appointments may be dismissed from the practice. If a patient cancels or misses a Saturday appointment, with less than 24 hours notice, they will not be offered a Saturday appointment again, and are subject to the same cancellation fees as listed above.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. If the account is in default and turned over for collection, you acknowledge that you will be responsible for all reasonable costs associated with the collection. If we have to take you to court, you agree the venue will be Wake County, North Carolina. You also agree to pay reasonable court costs and legal fees associated with your case.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to submit a request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Patients Name: _____ **Signature** _____ **Date:** _____

Responsible Party: _____ **Signature** _____ **Date:** _____
(if not the patient)