

Financial Policy

Lewisville Family Dentistry

6570 Shallowford Road

Lewisville, NC 27023

336-945-5555

This is an agreement between Drs. Liner & Browder, DDS, PA, in association with Dr. Amy Kinlaw, DMD, as 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 Drs. Liner & Browder, DDS, PA.

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

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.

Payment options if you have no insurance:

1. You choose to pay by __cash, __check, or __credit card on the day that treatment is rendered.
2. On treatment involving laboratory fees (partials, space maintainers, and orthodontic appliances) we require that you pay 50% on the preparation date and the balance on the completion or delivery date. (Normally two to three weeks later.)
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.

Payment options if you have insurance:

4. You choose to pay your deductible of \$_____ and any out-of-pocket portions at the time services are rendered by __cash, __check, or __credit card.
5. On extensive treatment (partials, space maintainers, and orthodontic appliances) we require that you pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion or delivery date.

Payments: Unless we approve other arrangements in writing, the balance on 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.

The Financial Policy continues on the backside of this page.

Patient's name: _____

Responsible party
(If not the patient): _____

Signature: _____ Date: _____

Co-Signature: _____ Date: _____

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, you are 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 ninety (90) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of 1.5% per month or an **ANNUAL PERCENTAGE RATE** of eighteen (18%).

Credit History: If your account becomes delinquent we have the option to report your account status to any credit reporting agency such as a credit bureau. Efforts will be made to collect the unpaid balance, before reporting to the credit bureau.

Required payments: Any co-payments required by an insurance company must be paid at the time of service.

Returned checks: There is a fee of \$25.00 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 48 hours notice can be charged a \$25 to \$50 fee. This is at the doctor's discretion. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs, which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees that we incur plus all court costs. In case of suit, you agree the venue shall be in Wilkes County, North Carolina.

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 case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a 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 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.

Workers Compensation: We require all services be paid in full and once workers compensation pays they can pay directly to you.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. We reserve the right to handle payment of these treatment plans on a case-by-case basis.

Co-signature: If another person signs this or another Financial Policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.