

Pediatric dental **ASSOCIATES OF RANDOLPH**

Aaron Mannella, D.M.D. Pediatric Dentist • Susan Arnold, D.M.D. Orthodontist
N.J. Spec. Lic No. 3709 N.J. Spec. Lic No. 3716



DENTAL INSURANCE AND FINANCIAL INFORMATION

Payment

Please be aware that the parent/guardian bringing in the patient to our office is responsible for payment of professional fees. We require payment at each dental appointment. We accept the following, checks, cash, Visa, MasterCard and American Express.

Dental Insurance

For our patients with **Delta Dental (the Premier or Point of Service Plan)**, **Horizon Blue Cross Blue Shield (Traditional or Dental Option Plan)** and **United Concordia** insurance coverage we will submit for you. For all other insurance carriers, we will provide you with an attending doctors statement at the end of each appointment, which you can attach to your insurance form. This form can be submitted to your specific dental carrier. Your dental carrier will then reimburse you for services rendered according to your benefit plan.

Any insurance policy is a contract that is between you, as the patient, and the insurance carrier. If you have any questions regarding your insurance plan, we ask that you contact your carrier prior to your appointment regarding the specifics and details of the plan.

Dental Insurance Facts

- Dental insurance IS NOT meant to be a Pay-All, it is only meant to be an aid
- You may receive notice from your insurance carrier stating that the dental fees are higher than reasonable and customary. How does an insurance company determine this? An insurance company may survey a geographic area, finding the average fee, for each procedure, take 90% of that fee and consider it customary. Most doctors fees are considered higher than average.
- Please be advised that many insurance carriers tell their subscribers that procedures will be "covered up to 80% or covered at 100%", but they DO NOT clearly specify plan fee schedule allowance, annual maximums or limitations.
- Some routine dental services are not covered by all insurance carriers.

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Our Financial Policy

Thank you for choosing us as your child's dentist/your orthodontist. We are committed to providing our patients with optimum dental care. Please understand that payment of your bill is considered part of you or your child's dental treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

We only submit to Delta Dental (Premier of Point of Service), Horizon Blue Cross Blue Shield of NJ (Traditional or Dental Option Plan), United Concordia and Met Life PDP for dental services provided. For orthodontic services we will submit to most insurance carriers on your behalf. We will not submit to any HMO or DMO plans.

Any information our office provides to you, has been provided to us by your insurance company. We assume no responsibility for the accuracy of the information received. In addition to our verification process we encourage policyholders to be familiar with all terms and conditions of their insurance plan.

Payment Agreement

I understand that my insurance contract is an agreement between the insurance company and myself. I acknowledge that your office is willing to prepare the necessary reports and assist me in collecting from the insurance company, which is due for my child's/my dental care and treatment.

I understand that at the time of service I am to pay my portion of the balance in full if the office participates with my insurance carrier. If the office does not participate with my carrier, I understand that full payment for services are due and I will submit to the insurance for reimbursement. In the unlikely event that my account is sent to a collection agency I am responsible for a 29% collection fee.

I understand that 24 hours notice is required for the cancellation of appointments, and I will be charged \$45 for missed appointments without proper notice. I also understand that most insurance carriers will not reimburse the cost of a missed appointment.

I hereby authorize you to charge payment of unpaid amounts, including the payment of missed appointments to my credit card listed below.

Please note that if you do not wish to divulge your credit card information, you are responsible for payment at the time of service. We accept cash, check, MasterCard, Visa, American Express and Discover.

Amex/Discover/MC/Visa Number _____ Exp date _____

I have read and agreed to the above financial policy.

Parent/Guardian/Self Signature

Date