

Financial Policy

We are pleased that you have chosen the University of Texas Dental Center for the evaluation and management of your restorative needs. We hope that your experience here will be exceptional.

We strive to communicate clearly and effectively with you in all aspects of your care. We have created this policy so that you understand our expectations regarding insurance and payment for services. If you have any questions, please address those to the front office staff or office manager before you sign the acknowledgement.

1. **Forms of payment:** Payment for services is expected the same day services are rendered. For your convenience, we accept Discover, Visa, Master Card and American Express, in addition to cash, checks and money orders. You will be responsible for paying a \$25.00 fee for returned checks.

2. **Insurance Benefits:** We will be happy to file your insurance benefit claims as an added service to you. However, it is important that you understand that your insurance company does not share financial responsibility for your bill. Unless you are insured by a federal or state funded program you are responsible for all charges if your insurance company fails to pay you.

Assignment of Benefits: In consideration of services rendered, I hereby transfer and assign to University Dental Center all right, title, and interest in any payment due me for services as provided in the policy or policies of insurance held by me or on my behalf. I agree to pay the University Dental Center the charges which exceed the amount paid by the policies held by me. I further agree and authorize the above named clinic to release any information requested by the insurance company(ies) or it's representatives.

3. **Pre-Authorization / Pre-Certification:** You are responsible for obtaining authorizations from your PCP for office visits, when required by your insurance company. We will be happy to see you without the proper authorization but you will be required to pay for the visit. For surgeries or procedures to be performed by our doctors, we will attempt to get the service pre-authorized. If the insurance company denies the service we will notify you. If you have a question concerning your benefits you should direct those to your insurance company.

4. **Patient portion vs. Insurance Portion:** Before a service or surgery is performed, we will attempt to **ESTIMATE** the portion of the service that your insurance company will not cover. We will notify you of that portion either orally or written and you will be expected to pay your estimated portion on or before the service date. For procedures to be performed in the operating room, your estimated portion will be due on or before the pre-operative visit. As mentioned above, the insurance portion is estimated and is never a guarantee of payment even after an authorization has been obtained (except for state and federal funded programs ultimately, your bill is your responsibility regardless of insurance benefits).

5. **Denied or Unpaid Insurance Claims:** We will do our best to work with your insurance company to receive reimbursement for your services. However, if an insurance company does not remit payment within 120 days of the service date, you will be responsible for the balance. We do not accept HMO plans. For this reason, we encourage you to communicate with your insurance company about your outstanding claims. Additionally, if the insurance company denies payment on service, and our attempts to appeal the denial fail, you are responsible for the balance. Unfortunately, this sometimes happens even after the service has been pre-authorized.

6. **Cancellation of Appointments:** If fairness to other patients and the doctor and/or hygienist we require 24 hours notice if you must cancel an appointment. We reserve the right to charge a \$50.00 fee for missed appointments without 24 hour notice.

AGREEMENT WITH FINANCIAL POLICY

I have read and agree to the above financial policy. I understand that I am ultimately responsible for all fees for services provided to me.