ORAL HEALTH CENTER of DELAWARE
AESTHETIC & SPECIAL CARE ASSOCIATES
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INSURANCE AND PAYMENT POLICIES

Payment Policy

We deliver the finest care at the most reasonable cost to our patients. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment. We accept the following methods of payment:

- Cash or Check (electronic depositing with a valid driver's license)
- Major credit card (Visa, MasterCard, American Express or Discover)
- Extended Payment Plan (Care Credit; for treatment amount over $300) **Please Inquire**
- HSA/Flex spending cards (Please Note: We are unable to issue refunds and will not be held responsible for services charged to them that are not in compliance with your specific plan. Please check before using these cards.

Patients Using Dental Insurance

Dental insurance is a great adjunct to help offset some of the costs of dental treatment. Generally, dental insurance only pays a portion of dental care and is a contract between you and your insurance company. We will be happy to bill to your secondary insurance as long as it is presented before the service has been rendered. Our office will collect any deductibles and **'ESTIMATED'** patient responsibility based on the dental insurance benefits at the time services are rendered. After the primary insurance payment is received, you will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the **'ESTIMATION',** we will either refund the amount to you upon your request or leave the credit balance' on your account to be applied toward future treatment. Should your insurance company fail to pay their portion within 6o days after we submit your claim, you will be responsible for the full fee.

Acceptance Agreement

I understand and agree with the above financial policy. I also understand that I am responsible for knowing my insurance benefits, maximums, covered and non-covered services, frequencies, etc. and are responsible for **ALL** fees for me or my dependent children regardless of insurance coverage and payments. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me.

Broken or Late Cancelled Appointment Fees

I am aware that I must give a minimum of **24 'BUSINESS HOURS'** notice if I am unable to keep my appointment. Multiple/Family appointments require **72 'BUSINESS HOURS'** notice. We reserve the right to charge a $35 fee which is not covered by any insurance and must be paid prior to your next appointment.

Patient Name: _____ Date: _____

Responsible Party Signature: _____ Name (if not patient): _____