John David Reed, D.M.D.
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(256) 533-6006

We strongly feel that all patients deserve from us the very best dental care that we want to provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policies.

Our office has always been happy to work with patients covered by dental insurance, but a necessary evil of the practice is dealing with the many dental insurance companies and the various schedules they have set up for reimbursement. It is a rare—very rare—dental plan that covers 100% of our fees. Here's why.

The fees we charge for dental services are the same for every patient, insured or not. A given insurance policy, however, is based on a fixed fee schedule—"usual and customary"— that may have nothing to do with the real world. Dentistry has changed very quickly, insurance fees have not. After all, insurance companies are profitable businesses, not dental benefactors.

It is important to remember that these insurance contracts are between you, your company, and the insurance provider selected by your employer. You must understand that we file the insurance as a courtesy to you, the patient, not because it is required for us to do so. We do this despite the fact that many of these plans only allow for 40+% less than fees we normally charge. Our standard fees here at this office are considered very reasonable in this area of the country and are simply determined by the cost of doing business competitively.

Office Billing Policies;

1. Co-payments for routine dental procedures will be due and payable the day of service. This will include, but is not limited to, emergency appointments, fillings, extractions, most periodontal (gum) treatments and the like.

2. When a crown is necessary in your treatment, your portion not covered by insurance will be due the day of service. This may be divided into two equal payments, the first due the day the tooth is prepared and the other at delivery 2-3 weeks later.

3. If your insurance company has not paid for services rendered within 90 days you will be responsible for the balance on your account. You may then be reimbursed by our office once we have received payment, or you may request your insurance company to make payment directly to you.

4. A finance charge equivalent to 1.5% per month (18% per year) will be applied to balances after 60 days.

I understand that I am directly and fully financially responsible to this dentist for charges not covered by my insurance. I further understand that such payment is not contingent on any settlement, judgment, or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment made within 90 days, it is my responsibility to pay my doctor's bill directly.

I further understand and agree, that if I fail to make timely payments on my account, I will be responsible for all reasonable cost of collection, including filing fees as well as a reasonable attorney's fee.

There will be a $30.00 charge on all returned checks and interest will accrue on all delinquent accounts.

I have read and understand the financial policies of this office and agree to the terms stated herein.

_____ _____

Patient Signature Date

Authorization to Release or Receive Medical Information and Authorization of Assignment of Benefits

1. I authorize this office to release or receive any information necessary to expedite insurance claims.
2. I authorize this office to file my insurance claims electronically.
3. I hereby authorize this office to bill my insurance company directly for their services.
4. I authorize payment to go directly to this dentist on any insurance benefits otherwise payable to me.
5. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to my dentist.

A photostatic copy of these authorizations and agreements shall be as valid as the original.

_____ _____

Patient Signature Date

John David Reed, D.M.D.

Receipt of Notice of Privacy Practices
Written Acknowledgement Form.

I, _____, have received a copy of John David Reed, D.M.D's Notice of Privacy Practices.

_____ _____

Signature of Patient **Date**