Dominion 1 Dental Group PLLC

Payment Agreement

Dear Patient,

Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective dental care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plans.

Payment Guideline:

- *We must collect any co-payments, co-insurance, and or deductibles at the time of service, unless other arrangements have been made in advance with our office.*
- *We accept* ***Cash,Checks,Money Orders and Credit Cards****(Visa, MasterCard, American Express, Discover)*
- *The remainder of your bill will be sent to your insurance company for payment to our office.*

If by mistake your insurance company remits this payment back to you please send it to us along with all paperwork sent to you. ***Please do not send payment back to the insurance company.***

When to Present Insurance Card?

Please present your insurance card at EACH VISIT. Specifically bring to our attention any changes ***(New card, new group #, etc.)*** *since your last visit. This protects you from paying a bill because we had the wrong insurance information. There is narrow* ***(30-45days)*** *to present an accurate claim to correct insurance company. Failure to do so could mean the claim may be denied. In addition if you have secondary insurance it will be filed on your behalf as a courtesy. However if we have not received payment from your secondary insurance, in a timely manner the balance will become your responsibility.*

Insurance Company Denies Payment?

1. *This is a pre-existing illness or condition that they do not cover.*
2. *You have not met your full calendar year deductible*
3. *The type of dental service required is not covered*
4. *The insurance was not in effect at the time of service*
5. *You have other insurance which must be filed first*
6. *You have exceeded your maximum dollar/visit amount*
7. *You did not have a referral # for your visit/service*

If your insurance denies your claim for any above reason our office cannot be responsible for this bill. Therefore you will be held accountable to pay denied amount in full.

I have read and understand my financial obligations I understand that this office will file an insurance claim on my behalf I assign the proceeds of such insurance claim to Dominion 1 Dental. I understand that I will be fully responsible for payment of any and all dental services denied by my insurance as applicable by State and Federal Law.

Patient Signature: _____ *Date:* _____