ACCENT
FAMILY DENTISTRY
B. BRENDA GONG, DDS., PA

https://www.accentfamilydental.com
86 E. Depot Street Tel : 919-346-3821
Angier, NC 27501 Fax: 919-639-3912

Office Policies and Financial Agreement

Welcome! Thank you for selecting us as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy. For your knowledge, our Financial Policy is outlined below:

- I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits.
- **I understand and agree it is my responsibility and not the responsibility of the dentist or the dentist staff to know if my insurance will pay for any dental treatment I receive.**
- I understand and agree **it is my responsibility to know if my insurance has any deductible, co-payment, out of network amounts, usual and customary limit, or any other type of benefit limitation for the dental services I receive.**
- I understand and agree **it is my responsibility to know if the provider I am seeing is a contracted in-network provider recognized by my insurance company or plan.** If the provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. **I understand this and agree it is my responsibility for all charges and to issue full payment.**
- **Patients are expected to pay for our services at the time they are rendered.** Patients with dental insurances are expected to pay the amount of their estimated co-pay and deductible at the time of service. **All emergency dental services or any dental service performed without financial arrangement must be paid in full at the time of services.**
- Payments may be made by using cash, Visa, Master card, or American Express or Care Credit which is only for healthcare expenses
    - **Full pay Cash Discount**: We offer a 3% accounting courtesy for all services over $300 that is paid in full prior to the commencement of services.
    - **A convenience Fee of 3.0%** will be charged to each **Credit Card Transaction**. Please note that the fee does not apply to other forms of payment, including cash or debit cards.
    - **Term Loan:** We partner with multiple financing companies that offer affordable payment plan options. Please ask our front desk for more information about available financing options. **Please note that you are responsible for making all payments directly to the financing company according to the terms of your agreement.**

Signature: _____ Date: _____

Insurance information:

- As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you to receive your maximum allowable benefits. In order to do this we need your insurance card and/or insurance policy number with you on your first visit of every calendar year or your benefit period.
- **Our doctor (Dr. Brenda Gong) will diagnose treatment based on your dental health, not your insurance coverage.**
- You **MUST** realize that:

- **Dental insurance is not really insurance** (a payment to cover the cost of a loss) **at all.** It is actually a money benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. **Most benefit plans are only designed to cover a portion of the total cost of a person's necessary dental treatment.** For example, a dentist may recommend a crown for a tooth that has extensive decay. However, the dental plan may only cover the cost of a filling. This does not mean that the patient does not need a crown, only that the benefit is limited to a filling.
- **If your insurance has not been paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays.** After 90 days the patient is responsible to pursue payment from the insurance company. All current documentation will be provided by mail in order to assist your inquiries. **The insured has a better ability to deal with the insurance company and the employer responsible for the policy.**

❖ **Collection Costs**: **If we do not receive payment under the terms of this Financial Policy and we refer your account to a collection agency.** We may charge to your account or otherwise collect from you our collection costs, including court costs and reasonable attorney's fees to the extent not prohibited by applicable law. We may report late payments, missed appointments or other defaults on your account to the credit bureau. If you believe that we have information about you that is inaccurate or that we have reported or may report to a credit reporting agency information about you that is inaccurate, please notify us of the specific information that you believe is inaccurate by writing to us at the address above.

❖ **It is possible to have some changes in the course of treatment during the procedure due to unexpected underlying dental conditions not showing on radiographs (X-rays).** There will be a fee for any additional procedure NOT included in the original treatment plan.

Appointment Policy

When you request an appointment, time is reserved with your provider especially for you so that we may be dedicated to your care. We understand that your time is valuable so we will see you on time. The below policies were developed to best serve all of our patients.

- **Late Arrival**: If you are 15 minutes late for your appointment, we may need to reschedule your appointment so that we may provide scheduled patients with the care that they deserve. If you are late for 2 appointments, we reserve the right to request that you contact us when you are available (same day) and if there is an opening, we will be glad to accommodate.
- **Rescheduling or Cancellation**: If you need to change an appointment, please notify us two (2) days prior to your appointment not including weekends. **Initials**_____
- **Short Notice Change of Appointments**: If you cancel/change your appointment without proper notice (48 hours) twice, we reserve the right to request that you contact us when you are available (same day) and if there is an opening, we will be glad to accommodate. **Initials**_____
- **Missed (Broken) Appointments:** If you fail to appear for an appointment, we reserve the right to request that you contact us when you are available (same day) and if there is an opening, we will be glad to accommodate. If you fail to appear for three (3) appointments, we reserve the right to dismiss you from the practice. Also, we reserve the right to charge your account a $75 broken appointment fee for short notice cancellations or if you fail to appear for your appointment. This is determined on a case-by-case basis. **Initials**_____

Please indicate our understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the financial policy also shall cover your dependent children who are patients of the practice.

Patient Name (Please Print): _____ Date: _____

Patient's Signature/ Legal Guardian: _____ Date: _____