## *BAYSHORE DENTAL GROUP BILLING AND CREDIT POLICY*

Bayshore Dental Group is contracted with many PPOs (Preferred Provider Organizations). If we are providers for your insurance, we will help you receive the maximum allowable benefits. Simply bring your insurance card to our office and we will submit the claim for your primary and secondary insurance. You are responsible for any co-payment and unmet deductible at the time of service. *Please note:* Failure to provide proof of insurance may result in your being asked to pay for all charges at the time of service.

If we are not contracted providers for your insurance, we will courtesy bill your insurance company, so long as you pay a co-payment of twenty (20) percent and any unmet deductible at the time of service. If your insurance company does not pay within forty-five (45) days from the date of the billing, we will need to make arrangements for you to pay the balance of your bill.

We make every effort on your behalf to obtain payment from your insurance carrier for our services. *However,* since we have no way of knowing the exact details ( covered services,their fees, exclusions, limitations, and co-payment and deductible status) of your particular plan, it is your responsibility to determine in advance the specifics of your insurance coverage. If your insurance company denies payment of your claims, you will assume full responsibility for these charges.

If you have no insurance, or the service provided is not a covered benefit, then payment is due at the time of service. For your convenience, we accept cash, checks, Visa, and MasterCard.

*I have read and understand the financial policy of Bayshore Dental Group and accept the financial responsibility for all dental charges incurred by me or my dependents. If Bayshore Dental Group is a contracted provider, BDG agrees to accept the contracted rates for covered services, and I will be responsible for any deductible, co-payment and/or uncovered services. If BDG is not a contracted provider, I understand that any unpaid balance left by my insurance company will be my full responsibility.*

*Patient's signature:* _____

*Date:* _____ *Responsible Party:* _____

*Relationship to Patient:* _____