BRET A. AVRA, DMD, PSC
OFFICE FINANCIAL POLICY

Patient Name: _____
Date:_____

BASIC POLICY: Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks, credit cards, direct debit bank cards and Care Credit (see office manager). There is a **$25.00 returned check fee** due and payable from you for each check payment returned to us by your bank.

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper paperwork is provided to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

CARECREDIT: Our financing is done through CARECREDIT (if approved) which offers No Interest for up to 12 months or Low Interest for up to 48 months Payment Plans. www.carecredit.com or 1-(800) 365-8265.

MEDICAID: This office participates with Anthem Blue Cross Blue Shield of Kentucky only.

MEDICARE PATIENTS: In general Medicare does not cover any tooth related procedure.

WORKER'S COMP: This office does not participate with Worker's Comp.

TREATMENT FEES: All co-payments, deductibles and payments for non-covered procedures are due at the time services are rendered.

NON-COVERED CHARGES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor, **we require at least 24 hours' notice when cancelling an appointment or you will not be rescheduled at this practice.**

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance coverage, please read and sign below:

I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Bret A. Avra, DMD, PSC . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

Guarantor /Patient's Signature _____ **Date** _____

I have read, understood and agree to the above financial policy for payment of the professional fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME AT TIME OF SERVICE. BALANCES NOT PAID WILL HAVE A REBILLING FEE OF $20.00 ADDED EACH THIRTY DAYS BALANCE REMAINS UNPAID. I agree and understand Fees accumulated due to Non-Sufficient Fund Checks, Collection Fees, or any Court Cost will be my responsibility.

Guarantor / Patient's Signature _____ **Date** _____