Michael J. Hanna, D.M.D. Pediatric Dentistry, P.C.
Diplomate of the American Board of Pediatric Dentistry, Fellow of the American Academy of Pediatric Dentistry
1229 Silver Lane, Robinson Township, PA 15136 • 412-859-3199

Financial Policy & Dental Insurance

We are committed to providing you with the best possible care. If you have dental insurance, we can help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment is due when services are rendered unless payment arrangements have been approved in advance. We accept cash, local checks, debit cards, Care Credit, Discover®, MasterCard® or Visa®. We will be happy to help you process your primary insurance claim.

Returned checks are subject to a $40 fee. Balances over 30 days will be subject to additional interest charges of 1 ½ % per month and a statement fee. Balances over 60 days for which there are no mutually agreed upon payment plans will automatically be turned over for collection with charges for registered mailings, court costs, office and personnel expenses, collection fees, late fees, attorney fees, and other legal fees added to the balance. Once an account is reported to collection, the patient will be discharged from the practice.

We reserve time for your appointment and require 48-hours notice if you are unable to keep your office appointment. Hospital admissions and IV anesthesia cases require two weeks notice of cancellation. If you do not provide this notice of cancellation, you will be charged $50 to help cover the expense of reserving that time for you. There may be additional charges for hospital admissions and IV anesthesia cases. You must pay these charges before we can schedule another appointment for you.

We will gladly discuss your proposed treatment and answer any questions. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. A deductible or co-payment is involved that must be paid by you. If you do not pay your co-payments and deductibles, you will not receive the contractual discounts with your insurance carrier.

2. Our fees are generally considered to fall within the acceptable range by most insurance companies and, therefore, are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of "U.C.R." (usual, customary and reasonable fees for this region). Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies, who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard cost of care in this area. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You are responsible for all services not covered by your insurance. Pre-determinations are made for services proposed in a treatment plan.

3. If the insurance carrier does not remit payment within 60 days of service, you are responsible for paying the balance in full. We reserve the right to collect the balance in full by any means necessary. We must emphasize that as dental care providers our relationship is with you, not your insurance company. While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date service is rendered.

The adult accompanying the patient must pay at the time of service regardless of who is the responsible party. In the case of divorced parents, we cannot mediate financial arrangements for you. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account**.** If you have any questions about the above information, please ask us.

I understand and agree that, (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all this information. I hereby authorize Michael J. Hanna, D.M.D., Pediatric Dentistry, P.C. to process payments as necessary to settle my account in full. My signature authorizes the transfer of balances to my credit card. My signature also acts as a direct assignment of my insurance benefits to Michael J. Hanna, D.M.D., Pediatric Dentistry, P.C.

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Print Patient Name Date

_____/_____
Print Patient Name Print Patient Name

_____/_____
Parent Signature Print Parent Name

_____/_____
Parent Signature Print Parent Name REV 3/11