

KIRKWOOD DENTAL ASSOCIATES, P.A.
FINANCIAL RESPONSIBILITY

Patient Name (PLEASE PRINT): _____

For all patients, it is necessary to have an easily understood financial responsibility policy whether or not there is dental insurance coverage involved. If there is dental insurance, as a result of the many different and confusing insurance company reimbursement policies, it is important for patients to understand how Kirkwood Dental Associates, P.A. ~ KDA will assist you with your insurance. The treatment recommended is based on the patient's need and not by what any insurance company will cover. Your treatment should not be governed by your insurance contract, which is a contract between you and your insurance company. While we would be happy to answer questions to help you understand your insurance coverage, your best resource would be to check with your insurance carrier directly. All patients/responsible parties must sign this form prior to being treated.

- It is necessary for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **Prior to or at each scheduled appointment**, we need you to provide your current insurance information for our files, to ensure claim(s) can be accurately submitted. It is your responsibility to inform KDA of any insurance changes (i.e. employer, insurance plan, etc.) or any personal changes (i.e. name, address, phone number, etc.) that will impact your insurance coverage.
- As a service to our patients, we will submit your insurance claim to your primary insurance company. KDA will provide all the information necessary to help you receive maximum benefit from your insurance coverage. However, it is the responsibility of the patient/insured to determine and understand the details, restrictions, and benefit limitations of your particular policy. KDA is not responsible for whether or not a service performed is a covered benefit and therefore will not assume responsibility for the insurance company's refusal to pay a claim. **PLEASE BE AWARE MOST INSURANCE PLANS HAVE A MAXIMUM AMOUNT OF BENEFITS THAT THEY WILL PAY PER PLAN YEAR.**
- If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, any appropriate balance becomes the responsibility of the Patient/Responsible Party and should be paid to us directly. You may then contact your insurance company for further information.
- If the patient has coverage with an additional insurance company, we will submit all secondary claims directly, along with a copy of the Explanation of Benefits from the primary insurance. If the primary insurance payment is sent to the insured, the insured must provide the Explanation of Benefits to KDA in order for additional insurance to be submitted. Otherwise, submission for additional insurance is the responsibility of the patient/insured. As coordination of benefits is unpredictable, payment from the additional insurance coverage may be paid directly to the insured.
- Insurance is a patient's benefit designed to assist in the financial obligation for services rendered to the patient by the dental providers of KDA. The patient is the one receiving the dental service and therefore the Patient/Responsible Party is ultimately responsible for payment for all charges on the account regardless of any insurance coverage.
- At, or prior to the time of service, KDA will estimate the anticipated insurance payment and will collect from the Patient/Responsible Party the estimated balance due along with any deductible which may apply. KDA cannot guarantee any estimated coverage. After the primary insurance payment is received, the Patient/Responsible Party will be billed for any difference between the estimated balance due and the actual balance due. Upon receipt of the statement, the remaining patient balance must be paid in full within thirty (30) days, unless a signed financial agreement has been approved. If the insurance payment is greater than what was anticipated, we will either refund the amount to the Patient/Responsible Party or leave the credit balance on the patient's account to be applied toward future treatment.
- In the event that the patient does not have insurance coverage or the insurance company sends the insurance payment directly to the insured, **CHARGES FOR SERVICES ARE DUE AND PAYABLE IN FULL AT THE TIME SERVICES ARE RENDERED**, unless a signed financial agreement has been approved.
- For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express (subject to change at the discretion of KDA). Dental payment plans through third party lenders, are also an option, upon application and approval from the lender. KDA reserves the right to charge the account a fee for any check returned unpaid by the bank. If a check is returned unpaid by the bank, your personal checks will no longer be accepted.

Insurance benefits are estimates only. I understand the insurance company makes the final determination of payment and eligibility and they may pay less than the actual bill for services and less than what may have been predetermined by them. I understand that I am responsible for any co-payments and deductibles, along with any payment for procedures that my insurance company does not cover. I am also responsible for any balance due because of insurance claims not paid within 60 days of service. I authorize KDA to release any information, including diagnosis and records of treatment rendered during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to KDA, insurance benefits, otherwise payable to me.

I understand that KDA reserves the right to charge a monthly billing fee or finance charge and to use a Collection Agency for the collection of my account and will charge my account any collection fees involved. If KDA initiates legal action to collect amounts due, I agree to pay pre and post judgment interest, court costs, and attorney's fees that may apply, as allowed by the law and the court. I further understand that if my account is sent to collections, all scheduled appointments will be cancelled, until the account is paid in full. At all times, KDA reserves the right to dismiss patient(s) from the practice for the below responsible party.

I have read and understand the above, and I agree to be responsible for payment of all services rendered and any billing/collection fees accumulated on the patient's account.

Name of Patient (Parent/Guardian if Minor) / Responsible Party (PLEASE PRINT)

Social Security Number of Responsible Party

Signature of Patient (Parent/Guardian if Minor) / Responsible Party

Date

Signed at: Kirkwood Dental Associates, P.A.