MONROE PEDIATRIC DENTISTRY
18 CENTRE DRIVE, SUITE #204
MONROE TOWNSHIP, NEW JERSEY 08831

GENERAL OFFICE AND FINANCIAL POLICY

THIS GENERAL OFFICE AND FINANCIAL POLICY (THE "POLICY") APPLIES TO ALL PATIENTS AND THOSE RESPONSIBLE FOR MAKING PAYMENTS FOR ANY SERVICES RENDERED BY MONROE PEDIATRIC DENTISTRY.

GENERAL POLICY PROVISION

- Payment in full is due at the time services are rendered. We gladly accept cash, checks, debit cards, and the following credit cards: Visa, MasterCard, Discover and American Express.
- The parent or guardian who brings the child for his/her visit is responsible for payment regardless of what individual circumstances may be or what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.
- Fees for treatment are guaranteed for sixty (60) days from the date of the check up when the treatment plan is presented (not the date when the treatment plan is signed). After such 60 day period, fees may be subject to change. Fees may also be modified if there has been a change in your insurance coverage, if applicable.
- Patients are responsible for keeping their scheduled appointments. We require at least 24 hours prior notice if an appointment cannot be kept, since the time has been reserved for your child. Please help us serve you better by keeping scheduled appointments. This policy is set in place so that we, at Monroe Pediatric Dentistry, may provide all our patients with appointments as needed. A broken appointment fee could be incurred if no notice is given in advance.
- There will be a $35.00 service charge for all returned checks.
- You will be responsible for payment of all costs and fees incurred, including attorneys' fees, should collection efforts be made in order to fulfill a debt.
- Parents and/or guardians are required to accompany and remain with their child/children during all visits to our office. If someone other than the parent or guardian will accompany the child/patient on a visit, written authorization from the parent or guardian must be provided to us prior to any treatment being performed on the child/patient.

THE FOLLOWING ARE SPECIFIC ADDITIONAL PROVISIONS TO THE GENERAL POLICY PROVISION WHICH MAY OR MAY NOT APPLY BASED ON YOUR METHOD OF PAYMENT OR INSURANCE PLAN:

INSURANCE POLICY PROVISION

- Your insurance policy is a contract between the insured individual and their employer. The amount of coverage you will receive will depend on the quality of the plan purchased by the employer, not the fees of Monroe Pediatric Dentistry.
- Please be aware that some, or perhaps, all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company. We are not responsible for any limitations in coverage that may be included in your plan. You are responsible for knowing the details of your specific dental plan. For example, your specific plan may only pay for a fluoride treatment one time per year and the doctor may recommend it more often. If you only want it one time per year, please let us know.
- In the event we obtain a predetermination of dental benefits on your behalf, please be advised that the predetermination is only an estimate provided to us by the insurance provider and is subject to change. You will be responsible for full payment for all services rendered regardless of whether the amount due for such services is in excess of the predetermination amount.
- Most dental insurance policies have a period maximum. It is **your responsibility** to know your plan's maximum and to keep track of how much has been used. When the maximum for the period has been used, you will be responsible for all fees incurred.

1. FOR PATIENTS WHO HAVE DENTAL INSURANCE THAT ALLOWS THE PATIENT TO GO OUT-OF-NETWORK AND ALLOWS MONROE PEDIATRIC DENTISTRY TO ACCEPT ASSIGNMENT OF YOUR INSURANCE BENEFITS-THE FOLLOWING SHALL APPLY:

- Monroe Pediatric Dentistry requires that you pay for the first visit in full.
- PLEASE UNDERSTAND that we will file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We also cannot be responsible for any errors in filing your insurance.

- Please understand, when we send the claim, Monroe Pediatric Dentistry will be accepting assignment of your insurance benefits. The insurance company will then pay Monroe Pediatric Dentistry directly. Once we receive the funds we will either use the credit on your account towards future treatment or refund the money to the insured individual.
- As a courtesy, for all future visits, we will ask for a deductible and only an estimated portion of your child's dental bill. We will then submit the claim and wait for the payment from the insurance company. You will only have to lay out a portion of the bill. We can only estimate what your insurance company will pay. Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. If you end up with a credit on your account, Monroe Pediatric Dentistry will give the payee the option of choosing to either apply this credit towards future treatment or refund the money to the insured individual. If there is a balance on your account, Monroe Pediatric Dentistry will issue you a statement and require payment in full immediately.
- The office cannot carry balances longer than 60 days regardless of insurance payment. You are responsible for any balance on your account after 60 days, whether insurance has paid or not. We will be glad to send a refund to you once the insurance has paid us.

2. DELTA DENTAL PREMIER, UNITED CONCORDIA COMCAST UNIVERSAL PLAN, HORIZON BLUE CROSS BLUE SHIELD TRADITIONAL, CIGNA PPO AND UNITED HEALTH CARE PPO PLANS (WE ARE CONSIDERED AN IN-NETWORK PROVIDER)-THE FOLLOWING SHALL APPLY:

- Even though we are considered an in-network-provider your insurance contract may only pay a percentage of prevention and/or treatment. The percentage paid is usually determined by how much you or your employer has paid for the coverage or the type of contract your employer has set up with the insurance company. You will be responsible for the uncovered percentage at the time services are rendered. Monroe Pediatric Dentistry understands that the percentage of fees collected from the parent/guardian is based upon the Cigna PPO, Delta Dental Premiere, United Healthcare PPO, United Concordia Comcast Universal plan or Blue Cross Blue Shield Traditional fee schedule, whichever applies.

3. FOR PATIENTS WHO HAVE DENTAL INSURANCE THAT ALLOWS THE PATIENT TO GO OUT-OF-NETWORK BUT ONLY PAYS THE INSURED INDIVIDUAL AND THEREFORE, THE INSURANCE WILL NOT PAY THE DENTIST DIRECTLY-THE FOLLOWING SHALL APPLY:

- Payment is due at the time services are rendered.
- We will gladly provide you with the proper statements for you to submit to your insurance company.

In addition to this Policy, my signature below also serves as my signature on file for the following items (the first two which appear as #36 and #37 on the American Dental Association Dental Claim Form):

- Direct payment of the dental benefits otherwise payable to me (or the named insured), may be made directly to Monroe Pediatric Dentistry.
- The fact that I am responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with all claims.
- Authorization to Monroe Pediatric Dentistry to store ALL signatures, documentation and records, either past, present or future, in an electronic format as opposed to traditional paper formats. Signatures may be obtained through the use of an electronic signature pad. All signed documents will be scanned into our computer system and the original immediately shredded. Your scanned signature or signature obtained through the use of a signature pad will serve as an original signature that is legally effective and binding upon you.
- CONSENT FOR DENTAL TREATMENT – I request and authorize Monroe Pediatric Dentistry to examine, clean, give fluoride treatments and provide my child/children with comprehensive dental treatment including fillings, crowns, pulp therapy, extractions and nitrous oxide, if necessary. I further request and authorize the taking of dental x-rays as may be considered necessary by Monroe Pediatric Dentistry to diagnose and/or treat my child's/children's dental condition. I will allow photographs to be taken of my child/children or their teeth for diagnostic or educational purposes.

I have read the policy statements, from the previous page and above, and I agree to adhere by them. I understand that this form remains valid unless I cancel authorization through written notice to Monroe Pediatric Dentistry.

Signature of Party Responsible For Payment (Parent/Guardian): ______________________________

Please Print Your Name: ______________________________

Date: ______________________________