

EAST TAYLOR DENTAL, PC

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STATEMENT OF FINANCIAL RESPONSIBILITY

Billing & Insurance Policy for Oral Appliance Therapy

East Taylor Dental, PC is pleased that you have chosen us as your provider. We are committed to serving your dental and sleep medicine needs. The following is a statement of financial responsibility and our **Billing & Insurance Policy as it applies to Oral Appliance Therapy**. We require you to read and sign the policy prior to beginning treatment.

We want to ensure that we have thoroughly communicated the total costs you will incur for a custom fitted oral appliance from this office. It is important for you to understand that we will work with you by submitting a claim to your dental and/or medical insurance plan in an attempt to offer any supplemental monetary assistance you may need.

As a courtesy to you, our office will facilitate your care by providing assistance with any applicable insurance you may have; however, you must present accurate information regarding your coverage prior to or at your initial appointment. As you know, insurance companies vary widely in the types of coverage they provide. In cases where coverage is applicable, reimbursement will be delayed an average of 8-12 weeks. **Therefore, we require your estimated patient portion on the day the services are rendered.**

Please realize that many insurance companies reimburse professional fees on a complicated “fee averaging” basis; this estimated reimbursement provided by your insurance company may or may not be representative of fees in the Montgomery area. Unfortunately, we do not know the exact amount that your insurance company will pay because they only provide us an **estimated fee** for service. While our fees may be above or below the “usual and customary” rate provided to you by your insurance company, your portion is due in full at the time of your visit. In the event your insurance company reduces or denies payment, you – the responsible party, will be required to pay, all balances due from any treatment rendered.

Our staff members are very experienced with insurance matters and can generally answer any questions you may have. While we do our best to maximize your insurance benefits, you are ultimately responsible for your financial obligation to this office. If you have questions or concerns regarding your insurance coverage or payment, please contact your insurance company directly. It is **your responsibility** to encourage your insurance company to pay in a timely manner.

In-Network Providers

We are **contracted participating providers** for the following insurance plans:

Blue Cross Blue Shield of Alabama
Delta Dental Premier
United Concordia

We will expect payment of any applicable **co-payments at the time of service** as specified by your carrier. Our office reserves the right to assess both finance and re-billing charges on any unpaid co-payments or any balance that is a minimum of 60 days old. **Outstanding estimated insurance balances do not accrue interest and are NOT subject to re-billing charges.**

Out of Network Providers

If you have insurance coverage through any other insurance carriers, payment in full will be due at the **time of service** unless a prior **“Payment Plan Agreement”** has been structured and approved by the management of East Taylor Dental, PC.

FILING INSURANCE CLAIMS IS A SERVICE PROVIDED BY OUR OFFICE FREE OF CHARGE AND IN NO WAY RELIEVES YOU OF RESPONSIBILITY FOR YOUR BILL.

We will send all claims, including any required, supporting documentation to your insurance company. We may ask you to assist our office in acquiring reimbursement from your carrier if they have not reimbursed East Taylor Dental, PC within 45 days. Some insurance plans require a referral. If your plan requires a referral, you will need to contact your primary care provider to make sure all appropriate referrals are in place prior to starting treatment.

We recommend that you contact your insurance company to confirm the **percentage of coverage** for your care with this office. Your insurance company will ask you for a billing CPT or HCPCS code for treatment. The CPT code for an **oral apnea appliance** is **E0486 with an NU modifier**. This is the appliance code that would be billed **IF** you are diagnosed with **obstructive sleep apnea**. A billing CPT code of **S8262** will be submitted for a mandibular advancement device if you are being treated for a temporomandibular joint disorder.

Your Rights

As a patient you have the right to:

- Receive quality health/dental care
- Be treated with dignity and respect
- Obtain prompt and courteous treatment
- Expect total confidentiality
- Address complaints directly with Office Manager

Your Responsibilities

- Observe the right to privacy and confidentiality of other patients.
- Respect the staff
- Follow all pre-operative, operative and post-operative instructions
- Ask questions if you do not understand policy or procedures
- Address all complaints with Office Manager
- Fully fill out your forms, providing our office with accurate information

Your signature below acknowledges a complete understanding and agreement to the following:

- No finance charges will be assessed or billing charges applied if the balance is paid anytime prior to or within 59 days.
- When an account balance becomes 60 days old, a finance charge of 1 ½% per month will be assessed in addition to a re-billing fee of \$10.00 per month until the balance is paid in full. This is applicable to any past due co-payment amounts or insurance balance that remains unpaid 60 days or more.
- You authorize direct payment to the office of East Taylor Dental, PC for any dental or medical reimbursements for services rendered to you.
- You authorize the release of medical or dental records or any other information necessary to expedite payment on your account.
- In case of default of payment on your account, you understand and agree to pay collection costs, attorney fees, and court costs incurred in collecting on any future outstanding balances.

I have read, understand and agree to follow the policies as stated above.

Signature _____ Date _____

East Taylor Dental Representative _____ Date _____