Monica D. Schick DMD

108 Plaza Drive, Suite 102, Blandon, PA 19510

610-926-3226

Financial / Appointment Consent Form

For _____(patient name).

We welcome you and your family to the office of Dr. Monica D. Schick. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review and complete our office and financial policy consent forms. We will gladly discuss your proposed treatment, financial options and any other questions you may have. We strive to keep you informed and involved with your treatment as much as possible.

Dental Insurance

_____(initials) I/We **DO NOT** have dental insurance

_____(initials) I/We **DO** have dental insurance (if so, please continue below)

If you do have dental insurance, we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim and collect payments. If this information changes, it is the patient's responsibility to update Monica D. Schick DMD at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payment to Monica D. Schick DMD.

Monica D. Schick DMD will provide you with an ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/ you according to these estimates. It is possible that we could preauthorize any treatment to verify plan coverage and benefits.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as dental care providers, our relationship is with you, NOT with your insurance company. While the filing of insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date services are rendered. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and / or account holder.

Payment for services (copay/coinsurance) is due at the time the services are provided.

I/We understand the above paragraph regarding dental insurance, and have had the opportunity to have any questions answered to the best of Dr. Monica D. Schick's staff's ability.

_____ Signature of Responsible Party

_____ Date

Payment/Copays/Deductibles

Payment for copays and/or deductibles is due at the time services are provided. We have several options for payment of services, which may be paid in the following manner:

1. Payment by cash, check, Visa, Mastercard, or Discover
2. Payment by CareCredit. CareCredit is bank financing for qualified applicants who prefer additional time to pay their balance.

It is a revolving line of credit through an independent financial institution. It is designed to meet the needs of our patients and is ideal for extended treatment plans, elective procedures, emergency care, and treatment not covered by insurance. CareCredit has financing options available that include 3, 6, and 12 month interest free payment plans.

I/We understand the above paragraph regarding payment for services, and have had the opportunity to have any questions answered to the best of Dr. Monica D. Schick's staff's ability.

_____ Signature of Responsible Party

_____ Date

Account Balances / Charges

Returned checks and balances older than 60 days will be subject to additional billing charges. Any balance older than 60 days will be subject to interest charges of 1.5% per month until the account is paid in full. If a payment has not been received on the account for 90 days, the account risks being sent to a collection agency and additional collection fees will be applied to any unpaid balance. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient. We do understand that temporary financial problems may affect timely payment of your account. If this is a concern, we do ask that you contact us promptly for assistance in the management of your account. Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $25 NSF check fee to absorb bank charges to our office.

I/We understand the above paragraph regarding account balances/charges, and have had the opportunity to have any questions answered to the best of Dr. Monica D. Schick's staff's ability.

_____ Signature of Responsible Party

_____ Date

Cancellations and Broken Appointments

In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a **24 hour cancellation notice.** Your scheduled time has been saved only for you and the doctor and/or hygienist. Due to staff overhead that occurs in broken appointment slots, **a cancellation fee is charged if a 24 hour notice is not given.** Our message system will accept your cancellation calls for you and will record the time/ date of your calls to avoid a **$35 charge to your account.** We appreciate your efforts to keep scheduled appointments and we will make every effort to continue to have convenient hours and have prescheduled availability for you.

I/We understand the above paragraph regarding cancellation fees, and have had the opportunity to have any questions answered to the best of Dr. Monica D. Schick's staff's ability.

_____ Signature of Responsible Party

_____ Date