Dental Surgeons and Associates

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS

Dental Surgeons and Associates is a privately-owned dental facility that provides medical services on a fee-for-service basis. DSA relies solely on insurance reimbursement and patient payment(s) for services rendered in good faith. DSA receives no federal, state, or other third-party funding; as such, DSA does not have provision for providing on-going indigent care. The following Financial Agreement is developed in accordance with Office of Inspector General (OIG) guidelines as well as all applicable State and Federal reimbursement guidelines. For the convenience of our patients, DSA participates with most Dental insurance companies. DSA will submit claims for all medically necessary services to your insurance company. **Please note that payment is ultimately due from you if your insurance company denies payment for any service(s); i.e. termination of coverage, coordination of benefits, non-payment of premium, non-participating status, etc.** If we do not participate with your dental plan, we will provide you with an itemized receipt so that you may file with your insurance company for any out-of-network benefits to which you may be entitled.

Deductibles, coinsurances, and any non-covered services are the responsibility of the patient. To the extent possible and feasible, all patient financial responsibilities are payable at the time of service and / or prior to surgical procedures. Not all dental insurance companies publish their (allowable) fee schedule; therefore, coinsurance percentages cannot always be accurately calculated for prepayment. A DSA statement will be sent to you after your dental insurance has processed your claim(s); the balance due will compare to the Explanation of Benefits you will receive from your health insurance company. Should you dispute any amount on your Explanation of Benefits / statement, please contact your dental insurance company member services for clarification of your benefits.

Copayment(s), as stipulated by your dental insurance company, are due on the date of service. Please note that OIG guidelines (FR Vol. 65, No. 194, Oct.5, 2000) relative to anti-kickback statutes, as well as contractual obligations to the dental insurance companies from whom DSA will seek reimbursement for dental services, prohibit the routine discounting of published fees, “insurance-only billing” or waiver of any insurance-assigned charges otherwise due from the patient.

Self-Pay: In the event that (1) you are uninsured, (2) DSA does not have a participating relationship with your dental insurance plan(s), or (3) you elect to have non-covered medical services (i.e., cosmetic or other services determined by your dental insurance plan to be “not medically necessary”, etc.), DSA accepts self-pay patients with this signed agreement that payment is due on the day services are rendered or in the case of surgical procedures, payment is due prior to the surgical procedure(s).

DSA does not accept litigated cases and services are not provided on a contingency basis under any circumstances.

DSA is not a banking institution and does not assess finance charges to cover the operational cost of managing payments by installment; therefore, no internal financing options (i.e. budget or other installment plans) can be extended.

For your convenience, DSA accepts cash, check, money order and credit cards. In addition, DSA offers financing options through third party vendors.

I understand all the terms defined above; I consent to receiving treatment under the stated terms and I agree to honor all my financial obligations to Dental Surgeons and Associates. I hereby authorize the provider and its employees, agents, and assignees, to contact me via e-mail, text message and to my cellular device.

I hereby assign all medical / surgical benefits to Dental Surgeons and Associates for services rendered to me by the dental providers contracted under Dental Surgeons and Associates, and request that payment of authorized benefits be made to assignee on my behalf. I authorize release of any medical information as may be required by my dental insurance company to determine my benefits and issue payment to assignee for related dental claims.

My signature below constitutes my Financial Agreement, Assignment of Benefits, and Lifetime Signature Authorization.

Patient / POA Name Printed:____
Patient / POA Signature:_______________________________________ IF POA, relationship to patient:____________________________
Date :________________________________

Failure to honor your financial obligations to DSA in accordance with this signed agreement will result in your account being referred to collections and termination of the treatment relationship in accordance with the regulations that govern ethical dental care.