# Levesque Family Dentistry, PLLC

## FINANCIAL POLICIES

Levesque Family Dentistry accepts most traditional insurance plans and once we confirm your coverage, you will only be asked to pay at the time of service the estimated part of your bill that we think your insurance plan will not assist you with. We will submit your forms at no charge to you. After your insurance plan pays us, any remaining balance will be billed to your account. A statement will be mailed and payment is due within 20 days.

We cannot guarantee the amount your dental plan will assist you with, we simply estimate the amount **most** insurance companies pay based on **most** traditional plans.

You and your insurance company have a legal agreement and Levesque Family Dentistry is not involved in this agreement. You are our patient and we will treat **you**, not your insurance company. If your insurance company fails to honor our request for payment then any balance after forty-five days will be billed to you.

FIRST VISIT: Patients are expected to pay for their first visit at the time of treatment by cash, check or credit card. Patients who have insurance plans to assist them should forward all insurance information to us at least 3 days prior to their appointment so their coverage can be verified. It there is a deductible, or patient % portion, it is payable at the time of the visit.

ESTIMATES: Estimates will be given prior to treatment upon request by the patient.

PATIENTS WITH A DENTAL INSURANCE PLAN: We welcome dental insurance plans and are available to facilitate dealing with your insurance company. Assignment of benefits should be made to this office by signing the bottom of this financial policy. Accounts of persons not wishing to assign benefits are handled like non-insurance patients.

As a service to our patients, our office will continue to complete and submit all forms to insurance companies; however, it must be understood that dental benefit plans are an arrangement between your employer and insurance company. **You are responsible for all fees whether insurance pays or not.**

To minimize billings costs, the amount that we estimate to be your portion after your assistance from your benefit plan, will be due at the time of treatment. This amount is based on the limited information we have about your plan. We have no direct contact or contract with your insurance company. You are responsible to be familiar with the details of your plan prior to agreeing to treatment. We will be available to assist you in understanding insurance issues.

Other than Delta Dental Premier Plans, we do not accept any DMO's, HMO's, PPO's or discount dental plans. Your insurance must allow you to see any dentist that you wish. (If you have a list of dentists who participate in your plan, we will not be on it, except Delta Premier; however, you may be able to be covered here under "out of network" benefits).

PATIENTS WITHOUT A DENTAL INSURANCE PLAN: Payment is due on the date of treatment and may be made by cash, check or credit card. For extensive treatment, estimates will be given upon request. Payment is due in full at each visit unless alternate arrangements are made with our business assistants.

PROSTHETIC TREATMENT: Prosthetic treatment includes crowns, bridges, partial dentures, full dentures and implants. Since we are on a cash basis with our laboratories, half of your estimated patient portion is due at the time of the first prosthetic visit.

BROKEN APPOINTMENTS: A charge may be made for appointments that are not kept and have not been cancelled with 24 hours notice. If the appointment is on the first day of the workweek, the schedule change must be made by Thursday of the previous week.

CREDIT CARD INFORMATION: Payment may be made by Visa, Mastercard or Discover

RETURNED CHECKS: There will be a $25.00 charge on all checks returned for insufficient funds.

ANY QUESTIONS? Please ask our Business Assistants. They are here to help you!

I have read the Financial & Insurance Policies for Levesque Family Dentistry, PLLC and agree to the terms and conditions.

Signature (Patient, Parent or Guardian)_____Date_____