Sandhills Family Dental

275 N Main St. ~ PO Box 378 Valentine, NE 69201 * 206 NW. 4th Street Mullen, NE 69152
(402) 376-1942 * 1-844-376-1942

Thank you for choosing us as your primary dental provider. We are committed to providing you with quality and affordable dental care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance:** We are providers for Delta Dental, Blue Cross Blue Shield, Ameritas, Metlife, Aetna, Humana, and NE & SD Medicaid. If you are not insured by a plan we are providers for, half of the total is due at the time of service and we will bill your insurance for the remaining amount. If your insurance pays in excess of what we have charged, we will reimburse you for the credit amount. If you are insured by a company we are providers for, please see #2 below for your payment requirements at the time of service. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Co-payments and deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services:** Please be aware that some and perhaps all of the services you receive may be non-covered or not considered reasonable or necessary by Medicaid or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claim submission:** We will submit your primary claim and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company, we are not party to that contract.

6. **Coverage change:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receiver you maximum benefits. If you insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members will be seen on a cash basis only.

8. **Missed appointments:** Our policy is to charge after two missed appointments not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Consent to treat: I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims. I authorize the release of all medical information pertinent to my medical care and necessary to process my insurance claims. I will assign all medical benefits to Sandhills Family Dental. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this medical consent at any time by notifying this office in writing.

I have read and understand the payment policy & consent to treat and agree to abide by the guidelines explained.

Signature of patient or responsible party____ Date________________