A & E Family Dental

12613 Taylorsville Rd. Suite 117 Louisville, KY 40299
502-266-5355

Thank you for choosing us as your dental health provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. In order to keep our fees from rising dramatically and to minimize the expenses of billing and bookkeeping, the following financial policy will be in effect at our office:

All patients must complete our patient information form and insurance form before seeing the doctor.

- Estimated portion of payment is due at the time of service.
- We accept cash, checks, debit cards, Visa and Master Card.
- We offer an extended payment plan with prior credit approval.

Dental insurance does not cover 100% of the cost of your treatment. Because of this and the extreme delay in receiving payment from many insurance companies, you will be asked to pay your deductible and your **ESTIMATED** portion on the day services are rendered. We will **ESTIMATE** as closely as possible your coverage, but until we actually receive the insurance payment, it is only an **ESTIMATE.** We will assist you in dealing with your insurance company, but ultimate responsibility lies with you. Your insurance is a contract between you and the insurance company. After 90 days your account balance is due in full even if you're insurance has not yet paid. If the account is not paid within the 120 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and other expenses incurred in the collection of your account.

Late Payment Charges: If your minimum payment is not received by the due date, you may be assessed a late payment charge. The amount of the late payment charge to be assessed is the maximum amount authorized under the laws of the state of your domicile. In most states, the late charge will be $5.00 or 5% of the past due minimum payment, which ever is greater, with a maximum of $20.00.

Finance Charge: A finance charge is imposed on those charges not paid in full within 90 days of the date you were first billed for the charges. The finance charge is periodic rate of .66% per month with an annual rate of 18%. The finance charge is computed by multiplying the balance on which the finance charge is computed by the periodic rate shown above. There is a $4.00 minimum finance charge.

If you think that you have been billed incorrectly, or if you need more information about a transaction on your bill, please call the office and we will be happy to assist you. Every effort will be made to make suitable arrangements for payment but if the account fails to be paid and there are no arrangements made, after 120 days the account may be turned over to our attorneys and all collection fees will be billed to you, the patient.

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OFFICE POLICIES

In order to provide you with the best care possible, there are some guidelines we follow to keep the office running smoothly.

- Office visits are by appointment only, if you have and emergency, please call and we will work you in as soon as possible. Patients with appointments hold priority unless the emergency is serious. Therefore, there may be a wait if you are worked in. We appreciate your understanding and cooperation on this matter.

- If you can not make your scheduled appointment, it is necessary to inform the office 24-hours in advance. We will be more than happy to reschedule your appointment at a more convenient time for you. On your first missed appointment occurrence you will receive a warning letter. On your second missed appointment you will receive a $25.00 failed appointment charge to your account. After the third missed appointment, without 24-hour notice, the doctor reserves the right to dismiss you as a patient.

We strongly urge you to keep scheduled appointments especially if you are in the middle of treatment. We are usually booked 3-4 weeks in advance so any rescheduling will result in a delay in finishing your case. We do understand that emergencies happen and we will take that into consideration.

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered during the period of such dental care to third party payers and health practitioner. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for the payment of all services rendered on my behalf of my dependents.

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Signature Date