

## DR. TREY KALIHHER'S DENTAL OFFICE

### \*\*\* FINANCIAL POLICY \*\*\*

#### **THANK YOU FOR CHOOSING US AS YOUR DENTAL HEALTHCARE PROVIDER.**

Dr. Kaliher and his Staff are dedicated to serving your dental needs with the best professional advice, care, and service obtainable. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. We are glad that you are here and we want to do our very best for you. We sincerely hope that your visit will be pleasant and rewarding experience. If you have any questions during your dental exam, please feel free to ask.

#### **PRIVATE PAY PATIENTS:**

Full payment is due at the time of service. We accept cash, checks, MasterCard, Visa, and Discover.

#### **INSURANCE PLANS INCLUDING PPO, AND OUT OF NETWORK:**

In order for us to file your insurance we must have a copy of your current insurance card. If you do not have your insurance card at the time of service, full payment is due at the time of service.

If you have an insurance plan that we are not providers for, full payment is due at the time of service. We will gladly give you a claim form at the end of your appointment so that you may file the claim with your insurance company for reimbursement. In some instances, we may file your insurance as a courtesy; however full payment is due at the time of service.

If you have an insurance plan that we are providers for, you are responsible for all co-pays, cost-shares and deductibles. For unpaid claims over 60 days, full payment is due at this time.

Filing insurance claims is a service we provide free of charge, but in no way relieves you from the responsibility of your bill.

It is your responsibility to know your insurance policy rules and benefits. **PLEASE NOTE:** We file claims to many different insurance companies, and it is virtually impossible for us to know your individual policies. Please be aware that some, and perhaps all, of the services provided may be considered by your insurance company to be non-covered services and/or might be subject to a deductible in addition to your co-pay. You have the right to refuse any services rendered to you if you think they are non-covered services or not payable by your insurance company. We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnoses, co-pays, cost-shares, or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company.

It is your responsibility to let us know of any insurance changes in a timely manner. Please don't assume that we know that your insurance has changed.

\*\*\* CONTINUED ON REVERSE \*\*\*

**WORKER'S COMPENSATION:**

We do not file worker's compensation claims. Full payment is due at the time of service. We will however, give you a claim form at the end of your visit so that you can file the claim to receive payment.

**UNACCOMPANIED MINORS:**

We do not treat minors, unless prior consent is obtained by the parents (or guardians). Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card and/or paid by cash or check at the time of service.

**MISCELLANEOUS SERVICES:**

If in the future you should need copies of your records and/or Px-rays, we do charge a fee for these services. It takes our office ten to fifteen days in order to process a request, so please plan ahead.

**Non-Sufficient Fund Returned Check Fee is \$25.00. All outstanding accounts turned over to a collection agency will be assessed an additional charge of \$50.00.**

I understand and agree to this financial policy. I have read the financial policy and agree that a photocopy of this financial policy shall be considered as effective and valid as the original. Regardless of what insurance coverage I have, I am ultimately responsible for the timely payment of my account and I hereby authorize the payment of insurance benefits to be made directly to Dr. Trey Kaliher.

Thank you for understanding our financial policy. Please let us know today if you have any questions.

**NOTE: A copy of this form shall be as valid as the original.**

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Patient Name (Please Print)

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Responsible Party Name (Please Print)  
(if different from patient)

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Patient Responsible Party Signature

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Date