

**MAEDOT SEMO, D.M.D.**  
**Garnet Valley Dental**  
**91 Wilmington-W. Chester Pike, Suite 24**  
**Chadds Ford, PA. 19317**

**PATIENT FINANCIAL AGREEMENT**

In our effort to provide you with comprehensive, evidence-based dentistry that consistently exceeds the standard of care, it is imperative that you have a clear understanding of our financial policy. This Financial Agreement is in line with our philosophy of being informative, honest and forthright with regards to your financial responsibility. In the process, we also strive to provide you with an understanding of the role of dental insurance as it pertains to your treatment needs.

***DENTAL INSURANCE***

- Our office will verify coverage, file insurance claims on your behalf and accept assignment of benefits as long as you provide us with accurate information about your dental insurance.
- Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you and not your insurance company. This pertains to all insurance companies whether we are considered in-network, or out-of-network. Knowledge of benefits as well as maximums, deductibles, limitations, exclusions, waiting periods, etc. is entirely your responsibility.
- For dental treatment where a pre-authorization has not been submitted, an estimate of your fee will be provided. This estimate is derived from a summary of your benefits that is available on your insurer's website. Although we provide you with an estimate, we do not guarantee its accuracy. Benefits and associated terms differ from company to company and from one plan to another. Receiving our services indicates acceptance of your responsibility to pay regardless of our estimate.
- Generally, dental insurance will only cover a portion of your bill. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment unless payment arrangements have been made before hand.
- For extensive dental treatment, or if your dental plan requires it, a pre-determination will be submitted prior to initiating treatment. Pre-determinations generally reduce the risk of error when determining your coverage level; however, your insurer will inform you that a pre-determination does not guarantee coverage.

***PAYMENT POLICY***

- We accept cash, personal checks, debit cards, Visa, MasterCard and Discover. We ***DO NOT ACCEPT*** Reward Cards such as Visa Signature Preferred.
- For those who qualify, we also accept Care Credit and Lending Club. We encourage you to explore these financing options particularly if no insurance coverage is available.
- For patients with dental insurance, estimated co-pays are expected at the time of treatment. After dental insurance has paid its portion, a statement is sent to the mailing address on record if a balance remains. Payment is expected within 25 days of the statement date.
- If the insurance company does not pay in full within 45 days, it will be your responsibility to pay the balance due within 2 weeks.

## FINANCIAL AGREEMENT (CONTINUED)

### ***MINOR PATIENTS***

The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

### ***RETURNED CHECKS***

A \$25.00 charge applies when a check is returned by the bank.

### ***OVERDUE BALANCES AND COLLECTION FEES***

We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

- An account with an unpaid balance **past 90 days** will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.
- We reserve the right to contact you on your cell phone or home phone in order to collect or resolve any issue related to an unpaid balance.

### ***BROKEN OR MISSED APPOINTMENTS***

Appointments not kept or changed with less than 24 hours notice are considered broken and you will be charged a broken appointment fee of **\$40.00**. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

### ***RECORDS AND REIMBURSEMENTS***

Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your record or radiographs for a nominal duplication fee.

### ***CONSENT & AUTHORIZATION***

I hereby do authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Dr. Maedot Semo. Without any reservations, I agree to abide by the policies outlined herein.

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Patient's name (please print)

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Patient's signature (or parent/guardian)

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Date

For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.