# Muha Dental Office and Payment Policy

Thank you for choosing Muha Dental as your primary dental office. 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 developed this payment policy. Please read through and ask us any questions you may have regarding policies. Once completed, please sign in the space provided at the bottom of the form. A copy will be provided to you upon request.

1. **INSURANCE.** We bill most insurance companies, however, we are not providers with ALL insurance companies. If you are not insured by a plan with whom we are a participating provider, *all co-pays and deductibles are to be paid in full at the time of service.* If you are insured with a plan that we have a contract 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-pays and deductibles must be paid at the time of service.* This arrangement is part of your contract with your insurance company.

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 your insurance company. ***If for any reason your insurance company denies payment, you are responsible for payment in full at the first billing.*** Knowing your benefits are very important and are your responsibility. Please contact them to verify covered benefits prior to having services rendered.

4. **PROOF OF INSURANCE.** We must obtain a copy of your current valid insurance card to provide proof of coverage. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of your visit.

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

6. **COVERAGE CHANGES.** We will update your insurance card, name, address, and phone numbers at each appointment so that the appropriate changes can be made to help you receive your maximum benefits. *If your insurance company does not pay your claim within 60 days, the balance will be billed to you.*

7. **NONPAYMENT.** *If your account is over 90 days past due, you will receive a letter stating you have 30 days to pay your account in full.* We accept cash, check, Visa, Discover, MasterCard, and American Express. Please be aware that if your account remains unpaid, we will refer your account to a collection agency.

8. **MISSED APPOINTMENTS.** We require a ***24 hour notice***. If you cannot keep a regularly scheduled appointment, it is your responsibility to call our office to make changes. If you fail to contact the office regarding appointment changes, you will be considered a failed appointment. When a same day cancellation or missed appointment occurs, you will incur **a fee of $25 or more** which will be billed directly to you. **IF YOU ARE SCHEDULE FOR A LONGER PERIOD OF TIME, A HIGH FEE MAY OCCUR.** Patients who fail to cancel or do not show for three appointments in a one year period will risk being dismissed from our practice. If this occurs, you will have 30 days to find a new dental provider and we will only see you on an emergency basis in the interim.

Our practice is committed to providing the best treatment to all of our patients. Our fees are representative of the usual and customary charges for our area. Thank you for understanding our current payment policy.

***I HAVE READ AND UNDERSTAND THE OFFICE AND PAYMENT POLICES AND AGREE TO ABIDE BY MUHA DENTAL'S GUIDELINES.**

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Signature of patient or responsible party Date