Financial Policy

Jeremy Joseph D.D.S
5564 Wilson Mills Rd., Suite 203
Highland Heights, Ohio (440) 461-0203

We are pleased you chose us to facilitate and care for your dental health needs. In order for us to keep costs as low as possible for you, we require payments are made at time of service. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read, agree to, prior to any treatment.

Payment Options

- We accept Cash, Checks, Master Card, Visa, and Discover cards.
- We offer a **10% discount** to our patients who choose to pay in full at time of service with Cash or Check and a **5%** discount for credit or debit cards.
- We offer extended payment plans with no interest through Care Credit to those who qualify. Both offer flexibility and low payments for those who prefer low monthly payments.

Insurance

For those patients who have financial assistance from insurance, your estimated co-insurance amount is due at this time. We will continue to submit your claims for you; however, your insurance is a contract between you, your employer and the insurance company. As your dental provider, our relationship is with you, not the insurance company.

All charges incurred are the responsibility of the patient regardless of your insurance coverage. We will cooperate fully with the regulations and requests of your insurance company that may assist in your claim being paid. Disputes or denied claims should be directed to your insurance carrier and /or employer.

Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. ***If payment is not received within 60 days from the date of filing, or your claim is denied, you will be responsible for paying the full*** **amount**. If we receive any payment from your insurance company after you have paid your bill in full, we will remit the payments directly to you.

Emergency Patients

For emergency patients who are not a patient of record, we will file any insurance claims, but require payment in full. Once you are a patient of record, we will then only require your co-insurance.

Minors with Separated or Divorced Parents:

When two parents are each responsible for one half of the cost of a child's dental care, the

Returned Checks/NSF
A $25.00 fee will be assessed for all returned or NSF checks. We reserve the right to reject check payments once a NSF occurs.

Short Notice Cancellations and Broken Appointments
Each appointment is a reserved time for you and only you. Each time appointments are not kept; other patients who do value their reserved time for treatment are penalized.
$50.00 or more may be assessed for cancellations without a 48 hour notice or a missed appointment. We reserve the right to decline future appointments unless paid in full. We may also require your next visit be secured with a credit card deposit. The office and situation will determine what time this occurs.

I have read and understand the financial policies of Dr. Joseph.

I understand I am responsible for all fees incurred for my dental treatment.

_____Patient initials

I understand insurance plans are payment assistance plans; they are not designed to cover the entire cost of treatment. I understand my insurance carrier may pay less than the actual bill for services. I understand that I am responsible for knowing what my insurance company will cover. By signing this form I am accepting responsibility for all amounts not paid by insurance. I authorize assignment of benefits directly to Dr. Joseph and this practice.

_____Patient initials

I understand I am responsible for any and all charges that might occur if my account is turned over for collections.

_____Patient initials

*Signed*_____ *Date:* ____/____/____
Patient Signature

*Patient Name*_____
Print

Parent
Or/Guardian of: _____
Child's name if applicable