MICHAEL S. MEAD JR.
STATE-OF-THE-ART DENTISTRY PRACTICED WITH CARE. DDS

Privacy Practice Acknowledgement (to sign in-office)
I have received the Notice of Privacy Practices, and I have been provided the opportunity to review it. Patient Name_____ DOB_____ Please Print Signature_____ Date_____

FINANCIAL INFORMATION

At our practice, we believe that you deserve the best possible dental care, as well as a clear understanding of your financial responsibilities in receiving that care. We are available to answer any questions you may have. We want you to have the best understanding possible regarding fees, payment and insurance.

Payment is always due at the time of service.

We accept cash, personal and cashier's checks, MasterCard, Visa, and Discover. If you are in need of a financial option, we also work with CareCredit, who offers short and extended term financing options designed to meet your treatment plan needs on approved credit. Please inquire about current CareCredit financing options. We will be happy to help you apply if this is a suitable option for you.

Treatment of Minors: The parents or guardians of a patient under 18 years of age are financially responsible for all fees associated with the minor patient. When a minor patient turns 18 years old, the parent or guardian still remains financially responsible until our office is notified **in writing** of the new financially responsible party. The patient will be removed from the parents' or guardians' account once all balances are paid and written notification of the new financially responsible party has been received. Please plan ahead if a minor will be accompanied to an appointment with someone other than a parent or guardian. Payment for the appointment is due at the time of service.

Broken Appointments: A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we kindly request 2 business days notice, so that we may have the flexibility to schedule other patients who are awaiting important treatment.

Delinquent accounts: We make every effort to assist our patients in keeping their accounts current. Any patient balances not paid by their due date are subject to a 1.5% per day late fee. In the event that an account balance becomes seriously past-due, we may employ the services of a collection agency to secure payment. Any account turned over to a collection agency incurs a 20% delinquent account collection fee. If your account is turned over to a collection agency, you are responsible for all interest and collection agency, attorney and legal fees associated with the account.

In the event that a personal check is returned to us for non-sufficient funds, a $35.00 fee will be assessed.

Initials_____

Date_____

PLEASE READ AND SIGN THE REVERSE.

Dental Insurance

If you would like to use dental insurance benefits, we will gladly submit claims for you and will always do our best to help you receive your insurance benefits. In order to keep fees as low as possible for all patients, Dr. Mead is not contracted with any insurance carriers. We do accept all private care insurance plans. This means that we will work with literally hundreds of plans.

Here are some important things that we ask of you to help facilitate the process and avoid surprises:

1. **Know the details of your plan.** Your dental benefits are based on a contract made between you or your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Changes to insurance benefits can happen at any time. Our office is not made aware of changes in your eligibility, plan or benefits unless you tell us. Therefore, we do request that you remain informed of the details of your policy so that you understand any exclusions, restrictions or frequency limitations of your plan.
2. **Provide us with your current plan information.** We ask that you always provide us with your current insurance information including your insurance carrier's name, contact information, subscriber's name, ID and group number and subscriber's social security number. This will assist us in securing your insurance benefits as quickly as possible.
3. **We require payment in full for your portion at the time of service.** Dental benefit plans are not designed to fully cover all expenses for your dental care. Rather, dental insurance is meant to financially assist you in obtaining the treatment you need and/or desire. Therefore, you can expect to have some personal financial obligation.
4. **We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.** Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but may give you more details about your expected benefits. Keep in mind that pre-treatment authorizations generally do NOT guarantee benefits.
5. **If your insurance company sends benefit checks to the patient/subscriber, we will collect the full fee for your appointment on the date of service.** Many insurance companies will send benefit checks to us after we send a claim. However, some, including Delta Dental, send the benefit check to the patient or subscriber. If you have a plan like this or you have Delta Dental, we will collect the full fee on the date of service. We will still gladly submit a claim at the time of your visit, and your insurance company will send the benefit check directly to you.
6. **In the rare case that payment is not received from your insurance company, we will request payment in full from you.** We bill your insurance as a courtesy. We will do our best to obtain maximum benefits for you; however there are many factors that are beyond our control. If your insurance payment is not received within 90 days of your date of service, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you.

Again, we are happy to answer any questions you may have and to help you in any way we can. We want you to have the best understanding possible regarding fees, payment, and insurance. We personally thank you for your understanding and cooperation.

_____ _____

Signature of Patient or Responsible Party (if patient is a minor)

Date

_____

Printed Name of Responsible Party (if other than patient)