2017 PATIENT FINANCIAL POLICY & AGREEMENT

Please read and sign this agreement before we agree to accept assignment directly from your insurance company. This avoids any misunderstandings and facilitates the processing of your insurance claims. If you have any questions, please ask us. **Hudson Family Dental is in network with: Delta Dental Premier, BlueCross Blue Shield & Cigna.**
We accept all out of network plans that are considered an "open" plan, please be sure to read your benefits carefully.

- I understand that I am responsible for the estimated amount not paid by the insurance company on the day services are rendered. Unless financial agreement has been made in advance with our office manager.
- If after billing and contacting the insurance company more than three times or 90 days, whichever comes first, and payment has not been received, we will detach the insurance claim and make the patient fully responsible for the balance.
- I understand that after the insurance company pays Hudson Family Dental, there could still be a balance for which I am responsible to pay in full upon receipt of the updated billing statement.
- I understand and agree that if the estimate of insurance benefits indicates a large amount due by me and I feel I cannot pay it in full at the time of treatment, I can request a written financial agreement before treatment begins. (Terms to be discussed at that time.)
- If a minor is brought to the office without a parent, the adult bringing the child must be prepared to pay the balance due.
- I understand that all balances due over 30 days are subject to a 1½ % late charge per month (18% per annum).
- We will send statements to all patients monthly, regardless of insurance status.
- I understand that if my account goes to a collection agency, I will be responsible for all fees associated with the collection of my account.
- My signature below confirms I understand I am fully responsible for the full fee for treatment performed regardless the outcome from my insurance company's processing of my claim.
- My signature below authorizes Hudson Family Dental to release information to my insurance company necessary to receive dental benefits.
- My signature below also gives my authorization for payment directly to Michael A. Gigliotti, D.D.S.; insurance benefits otherwise payable to me.

It is our goal to help you receive the most out of your dental benefits. As a courtesy, we submit your insurance forms for you and allow assignment of benefits to us. As much as it is our goal to help with your insurance reimbursement, we must point out that your insurance is an agreement between you, your employer, and the insurance company. We are not a party to this agreement. Though we can be helpful with your insurance questions, we do not have the authority to make insurance decisions on your behalf. We cannot be responsible for the insurance company decisions about payment; this is between you, your employer, and the insurance company. Please take the time to understand your group's dental insurance limitation, maximum, deductible, exclusions etc.

PAYMENT IN FULL OR ESTIMATED COPAYMENT IS DUE AT TIME SERVICE IS PROVIDED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE WITH THE OFFICE MANAGER PRIOR TO TREATMENT.

________________________________ ____________________
Signature of Responsible Party Date

☐ **The check mark in the box indicates I do not have dental insurance & understand I am responsible for payment in full a time of service unless other arrangements have been made prior to my treatment.**