# GREGG W. McKENZIE, D. D. S.

124 ALPINE CIRCLE
COLUMBIA, SOUTH CAROLINA 29223
(803) 788-0900
PRACTICE LIMITED TO PERIODONTICS — FAX 788-0637 — DIPLOMATE AMERICAN BOARD OF PERIODONTOLOGY


## FINANCIAL POLICY

Our goal is to minimize your out-of-pocket expense. But above all else, we are committed to providing you with superior periodontal care. While we never attempt to distinguish ourselves based on cost, we fully understand that affordability is of utmost importance to our patients. If you have any questions regarding any of this information, please let us know.

The following is our Financial Policy, which we require that you read and sign prior to treatment:

- ***Self-pay patient charges and all patient portions are expected at the time of service***. Fees for consultation appointments will be filed with your insurance company, if applicable. However, they are not always covered by insurance.
- We cannot file your insurance if you do not have a copy of your insurance card and/or the necessary insurance information. Without a copy of your insurance card, you must provide the insurance company's name, phone number to verify benefits, policyholder's name, date of birth, and insurance identification number. Without this information, your account will be treated as self pay. ***We do require your social security number if the patient portion of the account is not paid in full.***
- Typically, dental insurance does not require a pretreatment authorization. However, we do file pretreatment estimates with your insurance company to determine what they will pay on your behalf. If the pretreatment estimate has not been received before your scheduled treatment we will telephone the insurance company in an attempt to get the necessary information. If we are unable to obtain the pretreatment estimate, we will estimate as closely as possible based on previous payments by your insurance company. We will refund you of any payment overage or bill you for any payment deficit. ***Any patient portion that is left unpaid could have additional collection fees added and will be the responsibility of the patient / responsible party.***
- As a courtesy, we do file charges with your insurance company. Charges not paid by your insurance company within 60 days will become due and payable by you unless other financial arrangements have been made through our office. We do accept Visa, MasterCard, American Express and Discover.
- The responsibility for payment of services rendered to dependent children whose parents are divorced or separated rests with the parent seeking treatment. Any court ordered responsibility judgment must be determined between the individuals involved and cannot be considered by this office. ***However, if we have a signed payment commitment from the other parent with all necessary contact information we will bill that parent.***
- If the necessary treatment is not a "covered treatment", you will be responsible for payment. We do try to have all of this information available prior to your scheduled treatment appointment, as well as payment arrangements on patient portions or uncovered treatments. However, it is the patient's responsibility to understand the insurance policy limitations.
- We are a dental specialty office Medicaid and/or Medicare typically does not reimburse the treatments offered. Therefore, we have "Opted Out" of filing both, Medicaid and Medicare. We do discuss payment options and develop payment plans that suit Medicaid and Medicare patients on an individual basis.
- A $35 service charge will be applied to your account for any returned check. If a check has been returned, we will only accept cash, Visa, MasterCard, American Express or Discover.
- ***We understand that from time to time cancellations and rescheduling appointments occur. Due to the nature of our specialized practice we ask that you please allow our office at least 24 hours business notice for cancellations or to reschedule hygiene appointments. Failure to do so will result in a no show fee of $50.00. Also, once a surgery appointment has been confirmed, please allow 48 hours for any changes, cancellations or to reschedule the appointment. Failure to do so will result in a $250.00 fee.***

Please be aware that any unpaid balance over 60 days is subject to collection procedures.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force.

Patient's name: ______________________________

Patient's Signature: ______________________________ Date: ______________