

Somers Dentistry, LLC Insurance and Financial Policy

Dr. David Somers, DDS
Dr. Mitchell Somers, DMD

Thank you for choosing Somers Dentistry, LLC. We are committed to providing you with the best possible care so you can achieve and maintain your optimum dental health in a respectful and caring environment. We thank you for taking the time to read and understand the policy outlined below.

_____Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefits will almost never pay for completion of your dental care. It is only meant to assist you.

_____We currently process all insurance plans. This means we work with literally hundreds of companies. Although we can maintain computerized histories of payments by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. 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. Keep in mind this is still not a guarantee of coverage. This does delay treatment but will give you more accurate **ESTIMATE** of your financial responsibility.

_____We will bill your insurance as a courtesy. If insurance does not pay within 90 days, 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. This is rare, but it is important that you recognize that the insurance you have is a legal contract between **YOU** and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____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 ask that you give at least 24 hour notice. Failure to follow this policy or failure to show up for your appointment might result in a \$55.00 charge for each hour of a missed appointment. After 2 occurrences, you may be required to pay a deposit in order to schedule further appointments.

_____ Payment is due at the time services are rendered. If we are filing your claim for you, copayment and deductible is due at the time services are rendered. We accept Visa, MasterCard, American Express, Discover, Debit, Cash, Check and CareCredit. For appointments over 90 minutes, if you have insurance, half of your copay is due at the time you schedule, and if you are a cash patient, \$200 is due at the time of scheduling. The remainder of the balance is due on the day of service.

I agree with the above conditions.

Print Name: _____ Date: _____
Patient/Parent Signature: _____