Dr. Chad Millay
1930 Petersburg Road
P.O. Box 227
Hebron, Kentucky 41048

Financial Arrangements 2018

Print Patient Name: ____________________________________
Name of Person Responsible for Account: ________________________
Relationship to Patient: _______________________

We are committed to providing you with the best possible care.

IF YOU DO NOT HAVE INSURANCE, payment is due in full at the time treatment is provided. For your convenience, we accept Cash, Personal Check, MasterCard/Visa/Discover/Amex and participate with Care Credit and Lending Club Healthcare Finance for 3rd party options. _____(Initial)

IF YOU HAVE INSURANCE, we will submit your insurance claim to your insurance carrier as a courtesy to you and will help you receive your maximum allowable benefits. Your insurance is contract between you, your employer, and the insurance company. The amount of coverage paid by your insurance carrier may be based on your insurance company's Usual and Customary Rates and/or Fee Schedule. If your insurance carrier only pays the patient directly, **you will be responsible** to pay at the time treatment is provided. We are contracted with Dental Care Plus, Superior Dental, Delta Dental Premier and Cigna PPO. **You are responsible at the time of your appointment for any deductible or co-payment not covered by the insurance company**, as well as any remaining balance that the insurance company fails to pay. **If your insurance company does not remit payment within 60 days, the balance will be due from you.** _____(Initial)

Dental insurance is not meant to be a pay-all: it's only meant to be an aid. Many routine dental services are not covered by dental insurance at all. If you should have any questions regarding your coverage, **YOU** should contact your company regarding the details of the plan that is conducted on your behalf. **It is your responsibility to know your insurance coverage.**

Many plans tell you you'll be covered "Up to 80-100%." In spite of what you are told, we have found that most plans cover only 15-80% of an average fee. It has been our experience that some insurance companies tell their customers that "fees are above the usual and customary" rather than saying "**Your benefits are low**."

ACCOUNT BALANCES: If your account balance becomes **60 days late,** a **5% late fee** will be applied each month. If your account becomes **90 days late**, your account will be sent **to collections**. All fees from the collection agency will be patient's responsibility. If your account is in collections or in late standing, no appointments will be given until balance is paid in full. Future visits due to late accounts will result in the patient paying in full at the time of service. ________ (Initial)

BROKEN APPOINTMENT POLICY

Appointments in our office are reserved exclusively for each patient and are also customized according to individual needs. For this reason, if you are unable to keep your reserved appointment, please give us at least **24 hours notice**. If you have a Monday appointment and need to cancel or reschedule, you need to contact our office no later than Thursday, the week before. We charge **$75 per hour** scheduled for all broken appointments, no shows, and rescheduled appointments if less than 48-hour notice is given. _____(Initial)

Additional Costs

I understand and agree to pay for ALL cost involved with a collection agency, small claims court and/or an attorney's fees if my account is not paid for in full. _____(Initial)

Dr. Chad Millay
1930 Petersburg Road
P.O. Box 227
Hebron, Kentucky 41048

Returned Checks

There will be a $40 returned check fee applied to your account if a check is returned. The account then must be paid by Cash or Credit Card. _____(Initial)

We must emphasize that as dental care providers, our relationship is with you **NOT** your insurance company. While the filing of all insurance claims is a courtesy we extend to our patients, **ALL** charges are **YOUR** responsibility. If you have questions about the above information or are uncertain regarding insurance information, **PLEASE** do not hesitate to ask us. We are here to help you.

I understand and agree that (**REGARDLESS OF MY INSURANCE**) I am responsible for the balance on my account for any professional services rendered. I have read all the information on this sheet.

Signature of Responsible Party: _____________________________ Date: _________________