

TYSON BROSS, DMD, PhD, LLC
PEDIATRIC DENTISTRY

129 LUBRANO DRIVE – SUITE 300
ANNAPOLIS, MD 21401
PHONE: 410-224-0018
FAX: 410-224-4214

PRACTICE FINANCIAL POLICY

Thank you for selecting us as your dental health care provider. Our goal is to provide your family with the finest in Children’s Dentistry available. In this spirit, we have developed services that, when performed on a timely basis, can avoid more costly procedures later. The following information describes our Financial Policy. If you have any questions or concerns about our policies, please do not hesitate to ask one of our office staff. **Payment for services is due at the time services are rendered. We accept CASH, APPLE PAY, VISA, MC, DISCOVER. There will be a 3% convenience fee that will apply unless using a debit card.** We can also assist you in arranging financing through Care Credit. All financing arrangements must be completed prior to beginning treatment.

Financial Policy: After we have had the opportunity to verify your plan coverage, we will submit it as a courtesy on your behalf; However, if you have co-pay and any deductible, it will be due at the time of your visit. **Please note our agreement is with you, NOT your insurance company.** Because of this fact, if your insurance company refuses to pay or pays less than you think it should, you are responsible for the cost of your treatment and any insurance reimbursement problems. Our administrative staff will strive to help you obtain your maximum benefits by prompt and efficient processing of your claims. ****Please note if your insurance company cannot be verified on the same day or if we are out of network with your dental plan, you will be responsible to pay in full at the time of service. ** If your insurance company does not pay in full within 45 days, we will require that you pay the balance due at that time.** **Please be aware that the parent bringing the child to our office is legally responsible for payment of all charges. We cannot send statements to another party _____ (initial)

Insurance Benefits: Your dental benefits are based upon a contract made between you or your employer and the insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable or customary by your insurance company. If you have any questions regarding your dental benefits, please contact your employer’s human resource department or insurance company directly. We will, as a courtesy, assist you in filling out and submitting your insurance claim for dental treatment. **Insurance estimates may change:** During treatment it may be necessary to change or add procedures due to conditions found while working on your teeth. The insurance portion of the treatment plan is an estimate and not a guarantee of coverage. If your insurance carrier pays less than the anticipated amount, you will be responsible for the unpaid balance. **Please be aware:** If your insurance maximum has been reached or they cover less than we estimate due to limitations or exclusions, you may be responsible for MORE costs, including today’s treatment. _____ (initial)

Cancellations/Missed Appointments: We make a special effort to provide you and your family with quality dental care. This involves reserving a special time for you and your family to receive care. Should you have to cancel your appointment, please let us know **48hr business day notice.** With the rising costs of health care, these time slots are very expensive. You may be charged for a missed appointment at the rate of a normal office visit. After **1 cancellation without proper notice or missed appointments,** one may be dismissed from the practice. We apologize for such tough policies, but we are a small business and wish to set standards that make it possible to provide the highest quality of care. Please help us keep our practice and your healthcare affordable by keeping your appointments and by being on time. Upon late arrival we reserve the right to reschedule your appointment. _____(initial)

I have read and understand and agree to the above Practice Financial Policy	
Signature of Parent or Guardian:	Date:

Financial Policy Rev JUNE 2022

PRINT NAME OF PATIENT(S)