Chester County
Family Dentistry

David J. Montgomery, DDS
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915 Old Fern Hill Road
Building B, Suite 302
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p 610-431-0600
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FINANCIAL/PRACTICE POLICY

Welcome to our practice and thank you for selecting us as your dental health care provider. Our goal is to not only provide you and your family with optimal dental care, but also to make you feel as comfortable as possible. Our practice is committed to providing the best treatment for our patients. We encourage you to ask questions and to be involved in treatment decisions.

INSURANCE INFORMATION: Chester County Family Dentistry is an **"OUT OF NETWORK PROVIDER"** with all PPO insurances. This practice is **NOT** contracted with **ANY** insurance company. We **DO NOT** accept HMO, DMO, MEDICARE, OR MEDICAID plans. Please contact your insurance company or HR Department for complete details regarding **OUT OF NETWORK** benefits and to see if you are able to see an out-of-network provider before initiating any dental services.

As a courtesy to our insured patients, we submit claims to your insurance company. Please be aware that some services you receive may be non-covered or not considered "reasonable" or "necessary" by your insurance. We will help you to receive your maximum allowable benefits. To do this, we need your insurance card and/or policy on your first visit of every calendar year. If your insurance changes, please notify us before your next visit so we may make appropriate changes to help you receive your maximum benefits.

FINANCIAL AGREEMENT: Patients are expected to pay for services at the time they are rendered. Our patients who have dental insurance are expected to pay the amount of their estimated out-of-pocket and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard, American Express, and/or Discover. We also offer **CareCredit**, which is a financing option that is available for your dental expenses. A statement will be sent after all insurance payments have been received and applied to your account.

Partial payment will not be accepted unless otherwise negotiated with our financial specialist.

Optional Payment Terms:

- **Full pay cash/check discount:** We offer a 5% courtesy for all services over $500 that are paid in full prior to the commencement of services.
- **Term loan:** By arrangement with **CareCredit**, we can offer patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty for qualified patients. Please ask for details.

If none of the listed options assist with your dental needs, please speak with our financial specialist.

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COLLECTIONS/DELINQUENT ACCOUNTS: Accounts with balances outstanding beyond 60 days may be considered delinquent. If payment arrangements have not been made or if agreed-upon payments are not received, the account may be referred to an outside collection agency.

Chester County Family Dentistry utilizes **American Profit Recovery** for collection services when necessary. In the event your account is referred to collections, you agree to be responsible for any additional costs incurred in the collection of the debt, including but not limited to collection agency fees, court costs, and reasonable attorney's fees as permitted by law. We encourage patients to communicate with our financial department prior to delinquency to discuss payment options.

APPOINTMENTS: In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least a **48-hour notice** for any cancelled appointments. After **3 missed or cancelled appointments**, we will place you on a short notice list, which means we will contact you when an appointment time becomes available within the next 12 hours.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

Patient's Name (please print):_____

Patient/Guardian's Signature:_____ **Date:** _____