Community Health Connections

We take great care of you!

Payment Agreement

Thank you for choosing us as your dental provider. We are committed to providing you with quality and affordable health care. Please read the following payment policy and direct any questions you may have to our Billing Department.

1. **Insurance**. We participate in most insurance plans, including Medicaid. If you are not insured by a plan we do business with, and do not qualify for a sliding fee based on income, payment in full is expected at each visit. If you are insured by a plan we do business with but you do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments, coinsurance, deductibles.** Co-payments, coinsurance, and deductibles **must be paid at the time of service by the patient or the person accompanying the patient.** A co-payment, coinsurance, and/or deductible are part of your contact with your insurance company. It is your insurance carrier, not CHC that assigns a co-payment, coinsurance, and/or deductible as a patient responsibility. You will be billed if your insurance carrier notifies us at a later date that they have assigned a co-payment, coinsurance and/or deductible for a service. Failure on our part to collect co-payments, coinsurance, and deductible from patients can be considered fraud. Please help us uphold the law by paying your co-payment, coinsurance, and or deductible. CHC accepts payments in the form of cash, check or major credit card.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of the visit or if billed at a later date. Your dentist is required by your insurance carrier to document the services provided. Please do not ask us to alter documentation for insurance coverage or insurance payment purposes.
4. **Uninsured (self-pay) visits.** Payment for all services not covered by insurance is required at the time of service. CHC participates in a sliding free program, a service for non/under-insured individuals. Please ask for information on how to apply for the sliding fee program.
5. **Proof of insurance.** All patients must complete our Patient Registration packet before seeing the provider. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
6. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance on your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
7. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 90 days, the balance will be automatically billed to you.

8. **Non-payment.** If your account is over 60 days past due, you will receive a letter stating that you have 14 days to pay your account in full. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this occurs, you will be notified by regular mail and certified mail that you have 30 days to find alternative dental care. During that 30-day period, our providers will only be able to treat you on an emergency basis.
9. **Bounced checks.** There will be a $30.00 service charge added to your statement for any checks that are returned to us from the bank due to insufficient funds. You will be notified in writing and will be expected to provide payment in full.

I understand that it is my responsibility to know my insurance benefits for dental services rendered. I will be fully responsible for all remaining balances, co-pays, deductibles or balance my insurance company does not cover. Payment is expected at the time treatment is rendered.

I hereby authorize and direct my insurance carrier to issue the expense benefits allowed and payable to me under the terms of the insurance policy as payment for services rendered to me by Community Health Connections. I also hereby authorize and direct Community Health Connections to release any and all information from my dental records related to my dental condition in order to process claims. I verify that all information provided is true and correct. I agree to promptly notify this office of any changes in the information until my account is paid in full. I understand that my insurance will be billed as a courtesy and that I remain fully financially responsible for all charges that I or my dependants incur.

_____ _____

Signature of Responsible Party Date

_____ _____

Patient Name Date of Birth

2/2019