Diane T. McGinty, D.M.D., M.S.

PATIENT RESPONSIBILITY AGREEMENT and INSURANCE POLICY

If I do not have dental insurance, I understand payment in full is expected on the day of service. If I do have dental insurance, I understand that I will pay the ESTIMATED portion and deductible on the day of service. The insurance will be billed as a courtesy, however, please be aware if the insurance does not pay within 60 days payment in full is expected from the responsible party.

I understand that it is my responsibility to know what type of policy I have and if I have out of network benefits or not. If I am utilizing out of network benefits, I understand that the insurance company pays on a usual and customary fee schedule and that the fees charged by the Doctor are the actual fees. I am responsible for the difference between the Doctor's fee, and the insurance fee. I understand that the office is not contracted with any HMO policies and that if I have an HMO policy, I will be responsible for my full balance.

We will do our best in obtaining an estimate of your benefits. No Insurance company will guarantee an exact payment. Please keep in mind that all insurances relay a disclaimer when we call to check your benefits. This disclaimer states they are only giving an estimate of benefits and that it is not a guarantee of payment.

We will do everything we can to assist you in obtaining the maximum benefit of your insurance plan. However, the contract is between you and your insurance carrier. Therefore, you are ultimately responsible for payment in full of all services rendered.

If a CBCT scan is needed I understand that my Insurance will not cover this charge. A CBCT, also known as Cone Beam Computerized Tomography, is an x-ray technique that produces 3D images.

There will be a $25 returned check fee assessed to your account on all returned checks. The responsible party agrees to pay all attorney fees and court costs associated with collecting for services rendered. Collection fees of approximately 30% are added to the account when it is turned over to the collection agency.

I have read and understand the above policy's and agree to abide by them.

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Print Name (Patient or Responsible Party)

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Signature *Date*