Keely N. Lawson D.D.S., P.A.
General Dentistry

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Financial Policy

Thank you for choosing our office as your Dental Care Provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we require you to read and sign prior to any treatment.

Payment is due in full at the time of service, unless prior arrangements have been approved by our business manager. For your convenience, our office offers various payment options to assist you in paying for you and your family's dental treatment.

PAYMENT POLICY
We accept cash, local checks, all major credit cards, and debit* cards. *(*only Mastercard and VISA logo debit cards).*

CREDIT CARD POLICY
Person signing must be the name imprinted on the card.

CHECK POLICY
Current State Drivers license or State Picture ID required, a copy will be kept on file. A $35.00 fee will be charged for returned checks. This fee must be paid in addition to charges for treatment performed on the day of service within 48 hours from the day our office receives an Insufficient Funds Notice from the bank.

CREDIT POLICY
We will be happy to assist you with carefully planning your treatment as well as the fees involved. We do not give refunds on patient accounts, except in extenuating circumstances as deemed appropriate by the doctor. However, we will gladly extend any credit towards future treatment for you and/or your family.

CANCELLATION POLICY
Our policy for missed, rescheduled, or broken appointments is that they must be rescheduled ***at least 24 hours in advance***. Missed or rescheduled appointments may impact your scheduling conveniences. Any two missed or rescheduled appointments may lead to removal from the office as an active patient. Please help us to serve you and others better by keeping scheduled appointments.

INSURANCE POLICY
Upon accepting your insurance, our office will promptly file with your primary insurance carrier; however, payment is expected at the time of service. Please note that if your insurance carrier does not pay within 45 days of filing, we will expect prompt payment from you. Where applicable, this includes balance as a result of codes that are downgraded by your insurance company. If you have a SECONDARY DENTAL INSURANCE PLAN, we ask that ***you*** file with the secondary carrier. Our office will gladly assist you in completing your claim form(s) so that you can be reimbursed.

IN NETWORK AND DISCOUNT PLANS
All co-payments and deductibles are due at the time of service.

OUT OF NETWORK PLANS
We require any applicable deductible(s) and fees to be paid at the time of service for PREVENTIVE, as well as BASIC and MAJOR treatment. Additionally, 50% of our UCR (usual and customary rate) for Basic and 70% of UCR for Major treatment.

ROOT CANALS, EXTRACTIONS, PERIODONTAL and MAJOR treatment, must be PAID IN FULL by completion, CROWN/BRIDGE and DENTURES by insertion.

Patients with FEE SCHEDULES, THIRD PARTY and/or SELF INSURED PLANS, are required to pay in full; we will gladly assist you in filing your claims for reimbursement.

USUAL and CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance carrier's arbitrary determination of the usual and customary rate.

Please be aware that the doctor may recommend treatment that may not be covered under your plan in which case you will be responsible for payment.

I, undersigned, hereby agree in the event of default in the payment of any amount due, to pay additional charges equal to the cost of collection, including agency and attorney fees and court costs incurred that are allowable under the law(s) governing these transactions.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions.

I have read the Financial Policy.
I understand and agree to its terms.

_____
Signature of Patient or Responsible Party

_____
Date