Market Street Dental, P.C.
Insurance and Financial Policy

At Market Street Dental P.C. we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits here are some very important things you should know.

Your dental benefits are based on a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care, it is only meant to assist you.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service.) This means that we work with literally thousands of companies. Although we can maintain computerized histories of payments by a given company, they do change, therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your exact insurance benefits, we will be happy to file a pre-treatment authorization with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require.

Many people receive notification from their insurance company that dental fees are "above and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental companies define as "higher than usual and customary."

We bill your insurance as courtesy. If insurance does not pay within 90 days, Dr. Jacqueline A. Marcin reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that **the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges in our office.**

Dr. Jacqueline A. Marcin does require payment in full for your portion at the time of service. **We accept**: Mastercard, Visa, Discover, check, cash, money order, and Care Credit.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients keep their appointment. If you must change your appointment, we require at least 24 hours' notice to avoid a $30 cancellation fee (emergencies are an exception).

After Hours/Weekend Emergencies: In the event of an emergency after regular hours a $75 emergency fee will be charged for established patients in addition to the necessary treatment fee. Patients who are not established in the practice will be charged $125 after hours' emergency fee.

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatments and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been

recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $_35.00___ returned check fee. For any payment that I make by credit/debit card to the dentist or any collection agency to which account has been assigned, I authorize the dentist or collection agency to add to each such payment the fee or charge actually incurred by the dentist or collection agency for processing the credit card or debit card payment not to exceed $10 per payment.

Any account balances that remain unpaid for ___ days from the date of service shall accrue interest at the rate of 1.8 percent per year and may be referred to a collection company or attorney. In the event this occurs, I understand that I will be liable for collection costs of $_____. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, any agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient Signature: _____ Date: _____

Print Name: _____

Guardian/Responsible Party, if minor:_____ Date: _____

Print Name: _____