Financial Policy

Carolina Family Dentistry at Lake Wylie
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Lake Wylie, SC 29710

We are pleased to welcome you as a new patient. Our primary mission at Carolina Family Dentistry at Lake Wylie, PLLC is to deliver the best and most comprehensive dental care available. An important part of this mission is making the cost of optimal care as easy and manageable for our patients as possible. As we are sure you understand, to continue providing care we must receive prompt payment for the services rendered. Your assistance in seeing that your account is kept current is appreciated!

To assist you with your dental care investment, we provide the following payment options:

1. **Cash**- includes money orders and personal checks
2. **Visa/ MasterCard/ Discover**- We accept credit cards as payment for treatment.
3. **Payment Plan/ Care Credit**- Patient payment plans that allow you to pay over time with convenient low minimum monthly payments. With Care Credit, you enjoy the following benefits :

    *Flexible financing options
    *No annual fees or prepayment penalties
    *Quick and easy application
    *Receive a credit decision almost immediately
    *Start your recommended treatment immediately

We are happy to offer these choices so that you can select a payment option that best fits your needs.

*All patients are charged the same for services rendered. This office does not accept reasonable and customary charge calculations by outside parties, unless this office is a participating provider. Any adjustments/ write-offs will be applied upon receipts of payment and EOBs.

*Currently this office is a participating provider with Delta Premier, Delta PPO, Metlife PDP, and Cigna PPO

If we are a participating provider for your group policy, co-payments and deductibles are due prior to or at time of treatment.

Patient's with insurance

* We urge you to read your policy. The most common misconception concerning insurance is that your policy will cover the total cost of treatment fees charged. Insurance is designed to reduce your out of pocket cost, but usually will not eliminate it entirely. Your portion is due at the time of service.

*Your dental treatment is not dictated on what your insurance will cover. Together, Dr. Vargas and you create your treatment plan based on what your current medical and dental needs are. We cannot limit your care to just what is covered by your insurance plan. Every plan is different and each insurance company determines what is covered. Just because a particular service is not covered does NOT mean you do not need it.

*Insurance is filed as a courtesy to you and coverage does not relieve you of the financial responsibility, nor suspend payments until the insurance has paid.

*Insurance will only be filed for plans that we are provided with at the time of service. We will not "back file/ retro-file" any claims. You must provide all insurance information at the time of service. You are responsible for filing any claims with insurance plans we were not made aware of.

*If no insurance payment has been received within sixty (60) days of service, the patient is fully responsible for payment of the account. Please contact your insurance company to ensure your benefits are paid on your behalf.

***Remember insurance is filed solely as a courtesy to our patients.**
Please help us to keep this available to all patients.

Please read regarding estimate of benefits for dental treatment:

*We are not privileged to all insurance plans limitations and exclusions. You, as the beneficiary of the insurance policy, are responsible for knowing all policy limitations and exclusions. The contract for benefits is between you and your insurance company. Our only relationship is with you, the patient . We will prepare an estimate of insurance payment and your estimated responsibility. This is prepared using information provided by your insurance plan's representative. We only use the information they provide us, so if the information is not current, inaccurate, or lacking in detail, that will affect the treatment plan estimate we provide you. Neither we, nor the insurance company, can guarantee the estimated payment amounts. Please understand that the estimate generated is provided as a courtesy. We will assist you in understanding your benefits, but are not responsible for your benefits or what is ultimately paid by your insurance plan. We reserve the right not to accept assignment of benefits.

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Any discrepancies should be addressed with your insurance company or employer as they make the final determination of benefits provided, not us. You are responsible for verifying that all waiting periods have been satisfied prior to treatment. We cannot be held to the estimate of insurance benefits as it is only an estimate based on information provided on the day it is generated. Annual maximums, deductibles and percentages of coverage may be different on the day of treatment based on care received by other practitioners and the medical necessity of the procedure as determined by your insurance company. Please be aware that your particular program may base its allowances on a fee schedule, which may or may not coincide with our fees. Our practice is committed to providing the best treatment for our patients and we charge what is reasonable and customary for our area. You, as the patient are ultimately responsible for the full amount of the dental treatment cost regardless of any insurance company's arbitrary determination of usual and customary rates.

It is our policy to wait a maximum of sixty days for all insurance payments. If the insurance payment has not been received by this time, we will require you to pay your balance. You will be reimbursed any payments received from your insurance. Overdue statements will be charged a ***1.5% finance charge*** *for each month overdue.*

In order to ensure prompt dental care to our patients, we ask that you notify us 48 hrs in advance for cancellation of your appointment. We will apply a cancellation or no-show fee of 50$ without 48 hr prior notification. Ample notification allows us time to schedule another patient who needs dental treatment.

I Understand that I am personally responsible for my account for services rendered, including any services covered by insurance. I have received and read a copy of the Office's Financial Policy. I understand and agree to the financial policy. Further, I agree that if my account is not paid in full when due, I will pay the balance due plus cost of collections, including attorney's fees and court costs.

Signature of Patient/ or Guardian Date