Mark A. Kedzierski, DDS, PL *2990 Business Center Blvd., Suite A Melbourne, FL 32940*

FINANCIAL AGREEMENT

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Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement, please do not hesitate to ask our staff.

DENTAL INSURANCE

As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.

- Your insurance policy is a contract between you, your employer and the insurance company. We are **NOT** a party to that contract. Our relationship is with you and not your insurance company.

- You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable" all of which vary from one company to another. If we have contracted as a provider with your insurance, you are responsible for those contracted fees.

- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.

- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. **Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.**

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover. For those who qualify, we also accept Care Credit, which allows no interest financing for up to twelve months. If you choose to pay cash in full, on or before the treatment day we will gladly extend a 5% cash savings.

- After dental insurance has paid its portion, a statement is sent to the mailing address on record, for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.

- If the insurance company does not pay in full within 90 days, it will be your responsibility to pay the balance due within 2 weeks.

- We do not file claims for medical insurance.

PATIENTS WITHOUT INSURANCE COVERAGE

We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS

The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS

A $25.00 charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES

Finance charges will be applied to all balances not paid within 30 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVERDUE BALANCE

An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS

Appointments not kept or changed with less than 24 hours notice are considered broken. Broken appointments will be rescheduled during the morning hours and subject to additional fees. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 24-HOUR NOTICE NOT GIVEN

To reschedule or cancel an appointment, you must notify us at lease twenty-four (24) hours in advance to avoid a missed appointment fee of $25. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

RECORDS AND REIMBURSEMENTS

Original records including radiographs are the property of this office. If you desire, we will provide you with a copy of your record or radiographs for a nominal duplication fee.

CONSENT & AUTHORIZATION

I hereby do authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understand this document in its entirety, outlining office policies and financial policies of Mark Kedzierski, DDS, PL. Without any reservations, I agree to abide by the policies outlined herein.

FORM COMPLETED BY

Name_______________________________________Signature_____________________________________

IN CASE OF A CHILD:

Relationship to child ____ Date______________________

Are you the person legally responsible for this child? Yes ______ No _______

Reviewed by staff member ____________________________________ Date ________________________

Acknowledgement of Receipt of Notice of Privacy Practices

Dr. Mark Kedzierski

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

Date:____

For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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