BurkeDental
World Class Treatment. Hometown Care.

Financial Policy Agreement

Patient Full Name: _____

Welcome to the Burke Dental family. As a new patient, it is important to review the essential information regarding our financial and cancellation policies outlined below. Please ensure that you read all the provided details, as a **signature from the responsible party and the Social Security Number are required for your appointment**. We appreciate your cooperation.

CANCELLATION / RESCHEDULE / NO SHOW FEE:

To ensure optimal service for all patients, our office requires a minimum notice of **48 business** hours for any cancellations. Changes to the schedule made with less than 48 business hours' notice, as well as no-shows, will result in a fee of **$75 for cancellation, rescheduling, or failure to show**. This fee may be waived only in cases of medical, professional, or family emergencies, provided that appropriate documentation is submitted **(e.g., a doctor's note, repair receipt, photo of a thermometer, or a rescheduled flight**). Additionally, each account is allowed a maximum of two waivers for the cancellation fee, which will be granted at the discretion of the Burke dental team member managing the cancellation.

DOWN PAYMENT / DEPOSIT:

For all major procedures, such as gum and bone surgeries, crowns, implants, and fillings, a considerable amount of time is required from the doctor. To secure your appointment our office requires a deposit of $100 for any treatment exceeding $700. This deposit will be applied toward the total cost of your treatment. The rationale behind this policy is to ensure that the doctor's time is reserved appropriately, promoting fairness for all patients who are waiting for treatment. It is important to highlight that this deposit policy does **not** apply to routine cleanings, emergency visits, new patient examinations, or scheduled X-rays. *Additionally, if a scheduled treatment is canceled or rescheduled with less than 48 business hours' notice, a cancellation or no-show fee of $75 will be deducted from the deposit.*

PREPAYMENT DISCOUNT:

If patient would like to pay in full at the time of booking, we will extend a 10% courtesy discount for all Major treatment. We realize that not all patients will be able to make big financial decisions right away, which is why we offer 72 hours to take advantage of the 10% discount. This Discount cannot be combined with any active promotions.

IN HOUSE PAYMENT PLANS:

Interest free In-house payment plans are offered to patients that have extensive payment plan exceeding $1000 who have no prior cancellations/no-shows/long outstanding balances, and after it is approved by either the Office Manager or Dr. Ghanavati. For patients who do not qualify, we offer a 3-4 payment plan option with 3- 5% interest rate this ultimately depends on the deposit amount that is provided a minimum of 30% deposit is required. The only exception to this policy is patients who are on a payment plan for ortho treatment.

(Financial Policy Cont.)

3RD PARTY FINANCING:

We partner with a 3rd party financing company to help our patients who need financial assistance. In some situations this 3rd party allow us to offer 6 months deferred interest to the patient. These offers do not erase interest, but rather allow the doctor to pay the interest for the patient while they are situating their finances. Because of this, we CANNOT combine any treatment discounts with 3rd party financing. All treatment must be paid in full through the financing company, at this point, the patient is considered fully paid and treatment will be scheduled for delivery and the patient will set up their monthly payment schedule with the 3rd party independently.

INSURANCE:

When a patient provides us with their insurance plan information, our administrators will contact the insurance company for a full breakdown of benefits and coverage percentages. All copays are estimates and while we do our best to calculate copays based on those estimates, we cannot guarantee that the patient will not owe after the insurance claim is processed. All dental claims are submitted by the dental office as a courtesy to the patient, in the case denial of a claim/claims the dental office administers can provide help with appeals at their discretion. The dental office administers as a courtesy, will research, and collect insurance information but are not obligated to do so as the insurance policy is the patients. It is the patient's responsibility to understand their dental benefits and to follow up on ongoing claims, denials, and appeals. As stated above, we do our best to calculate copays based on insurance estimates, but it does happen that insurance will pay less than anticipated. In these instances, the patient is fully responsible for paying the remaining balance of treatment rendered.

Pending Open Claims:

For any procedures involving the delivery of night guards, crowns, implant crowns, dentures, or retainers, our office requires full payment to be made at the time of delivery. If you have insurance pending, you can choose to pay the remaining balance while we await the insurance payment, or you can opt to wait until the insurance processes the payment before scheduling the final delivery. Since Invisalign treatment typically spans several months, insurance payments can vary. If the insurance does not issue the final payment at the time of delivering the final trays, patients will need to cover the remaining balance that is pending insurance reimbursement. If you decide to pay the remaining balance for delivery, this amount will be refunded once the insurance determines your financial responsibility.

**********DENIED CLAIMS **********

All claims are submitted to the insurance company and are based on the negotiated fees established between our office and their insurance. However, if any claims are denied due to the annual maximum being reached or for any other unspecified reason, the office will then apply the office's standard fee rather than the negotiated fee, as these fees are contingent upon our contract with the insurance provider. It is ultimately the patient's responsibility to contact the insurance company to confirm that they have sufficient coverage for any services scheduled for future appointments.

Note: Please make sure to fill in the Payment Agreement Form in our office.

Patient Full Name: _____

Responsible Party Full Name: _____

Responsible Party Signature: _____

Date :_____