

**BRYAN DENTAL GROUP
BUSINESS POLICIES**

**442 West High Street, Suite 2, Bryan, Ohio 43506-1678
419-636-3163 or toll free 866-729-2434
www.bryandentalgroup.com**

Insurance: Insurance is a contract between your employer and the insurance company and reimbursements are based on the plan your employer chose. We are not a party to this contract in most cases. We will bill your primary and secondary insurance companies as a courtesy to you. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. You agree to forward to us any payments you receive from an insurance company for claims paid to you for services we rendered. If your insurance company requires a referral and/or a preauthorization, you are responsible to obtaining it. Failure to do so may result in lower payment from the insurance company. Please see the brochure *Why Doesn't My Insurance Pay for This?*

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time.

Divorce/Separation: In the case of divorce or separation, the party(s) responsible for the account prior to the divorce or separation remains responsible for the joint account. Upon notification, the adult patients on the account are given separate accounts. When an account involves minor child(ren) we will determine the responsible party, and that parent (or guardian) is responsible for those subsequent charges. If a divorce decree requires the other parent to pay all or part of the treatment costs, the responsible party must collect from the other parent.

Workers' Compensation: We will file claims with your workers' compensation carrier only with the proper authorization from you to do so. At your first visit, notify our staff so that the required information is obtained from you for accurate claims submission. If your worker's compensation claim is denied, you will be responsible for payment in full of services rendered.

Accidents: You pay by cash, check, debit card, or credit card on the day treatment is rendered. We will file claims with your school, medical, or automobile insurance company as a courtesy to you and assign payment to be paid directly to you. An authorization form is required to release any information to these third parties. We do not wait for payment due to any pending litigation.

Bankruptcy: In the event that an account balance is discharged due to bankruptcy, future visits will be paid in full by cash, debit card, or credit card on the day of service regardless of insurance coverage.

Waiver of Confidentially: You understand if your account is submitted to a collection agency, an attorney, if we litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned Checks: There is a \$25 fee for any checks returned by the bank.

Transferring of Records: You will need to request in writing and may be required to pay a fee if you want to have copies of your dental records sent to another dentist or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another dentist or organization, you authorize us to receive all relevant information, including your payment history.

Dismissal: Some circumstances warrant that a patient is dismissed from the practice. If you are dismissed, we will only treat you for emergencies for the 30-days following formal notice. After that time you will be required to seek a dentist in another practice.

Effective Date: Upon signing, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Guarantor name: _____

Signature: _____ Date: _____