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New Haven Dental Group LLC
www.newhavendental.com

NHDG Financial Policy

This form is to help you understand our financial policies and your responsibility in regard to charges incurred in our practice.

Participating Insurance Companies:
If you are insured by an insurance company with whom we **have** a contractual agreement, we have agreed to accept your plan's discounted fee. However, any non-covered services and remaining balance are your responsibility. You will be responsible to pay your estimated portion and/or any deductible owed at the time of service. **We will bill you for any balance remaining after your insurance company pays us and all applicable write-offs have been taken.**

Non-Participating Insurance Companies:
If you are insured by any insurance company with whom we ***do not*** have a contractual agreement, you will be responsible for your estimated portion and/or any deductible owed at the time of service. You are also responsible for any remaining balance that your insurance company may not have paid.

We file all dental insurance claims for you as a courtesy. This does not transfer your financial obligation to your insurance company.

It is your responsibility to inform us of any insurance changes. *If we do not have your current insurance information, then the total balance is your full responsibility.*

Regardless of your insurance coverage, we will provide you with the ***best possible estimate*** of your obligation and are happy to supply you with this information in writing upon request**.**

Please understand that it is your responsibility to know and understand your insurance coverage and that you are financially responsible for all charges incurred in our office. We are happy to assist you with any insurance questions you may have.

Non-Insured Patients
If you do not have insurance, please understand payment is due at time of service.
We now offer our own NHDG Savings plan. Please let us know if you are interested.

Accounts with past due patient balances are subject to a monthly finance charge. If you are unable to pay your account in full at the time of service, we will be happy to create mutually agreeable payment arrangements. As long as the terms of these arrangements are kept, your account will remain in our office for collection. If an agreed payment arrangement is not kept, we reserve the right to forward the account to an outside agency for collection.

I have read and understand the above policy. I give permission for any information regarding my dental care to be released to my insurance company and authorized billing agents for payment consideration.

Patient Signature:_____Date:_____

Patient Name:_____

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