

Aesthetic and Special Care Associates, P.A.

Thank you for choosing Aesthetics and Special Care Associates as your dental health care provider. We are dedicated to you and your oral health and are committed to the success of your dental treatment and want to provide you with the best and latest services available.

Information

Prior to receiving service, you must complete our patient information/medical history and HIPPA form, present your dental information and/or card(s), provide your social security number (for dental insurance companies that require this for claim submission), and a driver's license or photo id to comply with the government's Red Flag Rules to prevent insurance fraud.

Payment Policy

We deliver the finest care at the most reasonable cost to our patients. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment. We accept the following methods of payment listed below:

- ___ Cash or Check (electronic depositing with a valid driver's license)
- ___ Major credit card (Visa, MasterCard, American Express or Discover)
- ___ Extended Payment Plan (Care Credit; for treatment amount over \$300) **Please Inquire**
- ___ HSA/Flex spending cards (Please Note: We are unable to issue refunds and will not be held responsible for services charged to them that are not in compliance with your specific plan. Please check before using these cards.)

Patients Using Dental Insurance:

Dental insurance is a great adjunct to help offset some of the costs of dental treatment. Generally, dental insurance only pays a portion of dental care and is a contract between you and your insurance company. We will be happy to bill to your secondary insurance as long as it is presented before the service has been rendered. Our office will collect any deductibles and estimated patient responsibility based on the dental insurance benefits at the time services are rendered. After the primary insurance payment is received, you will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the estimation, we will either refund the amount to you upon your request or leave the credit balance on your account to be applied toward future treatment. Should your insurance company fail to pay their portion within 60 days after we submit your claim, you will be responsible for the full fee.

Acceptance Agreement

I understand and agree with the above financial policy. I also understand that I am responsible for knowing my insurance benefits, maximums, covered and non-covered services, frequencies, etc. and are responsible for **ALL** fees for me or my dependent children regardless of insurance coverage and payments. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me.

Patient Name: _____ Date: _____

Responsible Party Signature: _____

