Edisto Dental Associates, LLC
Patient Financial Policy

Patient Name: _____ **Date of Birth:** _____

Thank you for choosing **Edisto Dental Associates** as your Dental/Health care provider. We are committed to providing you with the best treatment available. We will bill your insurance as a courtesy to you with a copy of your current insurance card. If we do not have your insurance card, full payment is due at the time of service. We accept **Cash, Check, Master Card, and Visa.** There will be a $30 charge for returned checks. If payment is not received from your dental insurance carrier within our contract limits, any balance will be your responsibility. Our billing/insurance department is available to discuss any questions you may have regarding your insurance or account at **Edisto Dental Associates.**

Medicaid: We accept Medicaid for patients 21 and under. If there is a dental service not covered by Medicaid, you will be asked to sign a waiver and you will be responsible for the charges in full at the time of service.

PPO/Commericial/Medicaid: All co-pays are due at the time of service, we are members of most, but not all plans. You are responsible for verifying what your insurance plan will cover and that we are providers for your plan. You are responsible for referrals, payments of all deductibles and co-payments/co-insurance, procedures without authorization, non-covered charges as determined by your contract with your dental insurance carrier. All payments are due at the time of services.

Unusual and Customary Rate: We are committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. If we do not have a contract with your dental insurance company, you are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Self-Pay: If you do not have health insurance you will be responsible for all medical services rendered at **Edisto Dental Associates**. Payment in full is due at the time of service. If you are unable to make full payments, suitable payment arrangements will be discussed between you and our financial counselors.

Delinquent Accounts: If your account becomes delinquent, **Edisto Dental Associates**, will take the necessary steps to collect the debt, including but not limited to collection agency, lawyer, and reporting to a Credit Bureau where you agree to pay all the collection costs incurred.

I have read, understand, and agree to abide by its guidelines the payment policy regarding my financial responsibility to **Edisto Dental Associates**. For providing medical services to me or the above named patient. I certify that the information I provide to **Edisto Dental Associates** is, to the best of my knowledge, current, true, and accurate.

Patient Signature: _____ **Date:** _____

Guarantor Signature: _____ **Date:** _____
(If guarantor is not patient)