Charlestown Dental

Welcome to Charlestown Dental

12 General Warren Blvd, Suite 400, Malvern, PA 19355

Financial Responsibility Form

PATIENT NAME_____DATE_____

DENTAL INSURANCE

Welcome! Thank you for selecting us as your dental health care provider. Our goal is to provide you and your family with the best dental care at an affordable cost. We want you to feel as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

As a courtesy to our insured patients, we do our best to help you understand and work with your insurance policy, find out the allowed maximum, any deductibles and eligibility services. At Charlestown Dental, we gladly submit your insurance claims for you and will fully attempt to help you receive full insurance benefits. However, please remember that an insurance policy is a contract between you, and your employer and the insurance company, and we have no direct relationship with them. Because policies can change every year when contracts renew, often without clear communications. Changes in eligibility, maximums, or benefits could result in unexpected out of pocket cost. **Ultimately, all charges for services are your financial responsibility, especially if your insurance provides limited coverage or denies treatment coverage.** We will mail monthly statements to all patients with an outstanding balance. After 90 days of outstanding balance, we may enforce collections of any outstanding amount.

APPOINTMENTS

We reserve appointments especially for you, if you are unable to keep your scheduled appointment please inform us at least 24 hours in advance. Our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. For same day cancellations, there will be a **$25.00 fee, with the exception of emergencies.** After 3 missed appointments or cancelled appointments we will place you on a short call list, which means we will phone you when an appointment time becomes available on short notice. This gives you the opportunity to know if your busy schedule has an opening for a dental appointment within the next few hours.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover yours dependent children who are patients of the practice.

Signature: _____ Date: _____

Phone: 484.673.0400 Fax: 484.673.0401 Email: charlestowndental19355@gmail.com