ENDODONTICS
OF MICHIANA PC
Bradley R. Swanson D.D.S., M.S.D.

Financial Policy

Dental Insurance is a contract between you, your employer and your insurance carrier. Your dental insurance is not a contract between your insurance carrier and your doctor, unless your doctor is a panel provider for your insurance carrier and has contracted to a specific fee schedule with your carrier. The **estimated** payment for the primary policy will be due at the time of service. Let us know if you have secondary insurance so we can file it for you. In this case, you still pay the primary carrier's estimated payment at time of server, then you will receive, directly, your secondary carrier's covered reimbursement at your home.

The reimbursement levels will vary from one insurance carrier to another. One carrier may say they pay 80% for root canal treatment (endodontics), when what they actually pay is 80% of the carrier's fee schedule, which is usually far below actual fees for our geographic area. Factors such as deductibles, annual limits, and maximum allowable amounts per procedure cause reveals the discrepancy between insurance carriers and the real world.

Our office will file for you, at no cost to you, your insurance claim with your carrier at the time of services. You must provide us with accurate and complete data to properly obtain for you the maximum reimbursement levels. Our office will not be able to trouble-shoot claims which are delayed and/or contested by your carrier. However, we will provide you carrier copies of x-rays and/or written narration on your claim should your carrier require this level of documentation. Insurance claims assigned to our office and not paid by your carrier after thirty (30) days will be billed back to you, the patient, and are then due in full within ten (10) days. After sixty (60) days, unpaid accounts will go to collections. It is therefore very important that you take an active role in following your claim by telephone with your insurance carrier.

You carrier will be billed for the remainder of your payment and the funds will be returned to us. Any credit or debit will be returned or billed appropriately to you. If credit card is used, the card on file will be credited/debited appropriately.

Should your insurance company send payments on your behalf directly to you after service, we will require 100% of the fess payable for the services rendered that day.

NON-INSURED PATIENTS: All fees are payable on the day services are rendered. If we are unable to complete treatment on the 1st visit, we ask for 50% of the total fee be paid on the day service is started. The remaining balance is due upon completion of service.

We adhere to the most current technology available to date. Due to this use of state of the art equipment, some procedures performed in this office may not be a covered benefit of your insurance policy. THEREFORE, THESE FEES ARE THE PATIENT/GUARDIAN RESPONSIBILITY.

Should you have any questions, please ask a staff member, and we will do our best to assist you within our limits of expertise.

Fee Schedule

	Root Canal	Retreatment	Surgery	Miscellaneous
Anterior	1000-1100	1000-1100	1200-1300	Exam/Consult 100-120
Bicuspid	1200-1300	900-1000	1300-1400	Exam/Consult 100-120
Molar	1300-1400	1100-1200	1400-1500	Exam/Consult 100-120

Circle method of payment: Visa MasterCard Discover Personal Checks Cash

Agreement: I understand that this office has not contracted with any insurance company and will file my insurance as a courtesy. I understand that insurance benefits given at the time of service are only estimates and that I am responsible for the payment of this account. If the use of a third party becomes necessary to secure payment, I am also responsible for all collection/attorney fees and court costs. I understand that as soon as my insurance carrier issues a payment, or after thirty days, any unpaid portion of my claim will be charged to the credit card given, which I authorize to remain on file, without any interest or penalty from this practice. I authorize my insurance carrier to issue benefits directly to this office and also the release of any information necessary to process the dental insurance.

Patient (Guardian): _____ Date: _____