# Beth A. Gold, DDS & Amir Emam, DDS

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## Financial Policy

Welcome! Thank you for entrusting us as your healthcare provider. We encourage you to ask questions and to be involved in treatment decisions, while we help educate you about your oral health. In the interest of good healthcare practice, it is desirable to establish a policy to avoid misunderstandings. Therefore we wish to clarify the following points :

*Please initial the following indicating you have read each section carefully.*

### Insured Patients

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INITIALS

1. We are in-network with **Cigna, Delta Dental** & most **Regence** plans. As a courtesy we are able to bill most out-of-network plans however some, like most **Premera** plans do not make payments to out-of-network providers. Payments are made directly to you and therefore, we do collect full fees at the time of service. Unfortunately, we are not able to bill **Medicare** but will happily provide documentation so that you may do so.
2. As a courtesy to you, we will bill your dental insurance company. It is important to understand that your insurance policy is a contract between you and your insurance company and be aware that we are not a party to that contract. Should your insurance not make payment, you are responsible for the charges incurred for your visit. If a claim is not paid within 90 days of the service date you will be responsible for the total charges.
3. All copays, coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance carrier.
4. Dr. Gold and Associates main concern is your dental health and are confident in recommending treatment based on that premise, however, your insurance plan may consider some procedures as “non-covered” or “not necessary”. Dr. Gold and Associates do not diagnose treatment needs based on what insurance deems “necessary”.
5. You are responsible for monitoring your dental benefits. With regard to your maximum, be sure to inform us of all the paid benefits that have been sent to other dental establishments (i.e. Your general dentist, oral surgeon or other specialists.)
6. If you have a change in coverage, please notify us immediately so we can make the appropriate changes and expedite the processing of your claim.

### Non-Insured Patients

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INITIALS

1. Please note all charges incurred are due and payable in full on the date treatment is rendered.
2. We offer a 5% Senior courtesy to patients over age 65 when services are paid with cash or check. We cannot offer this discount if paying via credit card.
3. We offer interest free options with our partnership through Care Credit *(terms apply)*.

### Payment Options

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INITIALS

1. We accept all major Credit cards, Care Credit, Cash or Check. Please be aware if paying by Cash we do not have the ability to offer change, Cash is not kept on the premises.
2. We understand life is busy! We now offer secure payment solutions available via text or email.

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INITIALS

**Usual and Customary Rates**

1. Beth Gold and Associates are committed to providing the best treatment for our patients at a fair rate. We have submitted our office fees to Fairhealthconsumer.org and have determined to be within the guidelines of "usual and customary" for our area.
2. You are responsible for all unpaid balances, regardless of any insurance companies arbitrary determination of "usual and customary rates".

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INITIALS

**BROKEN Appointments**

1. A broken appointment constitutes as: Not showing up, Canceling without 24hr notice or arriving 15 minutes or later tardy. We make every effort to confirm appointments however, ultimately it is the responsibility of the patient to keep track of scheduled visits.
2. Frequent broken appointments may result in a **$100/hr** fee for hygiene appointments and **$250/hr** fee for surgical appointments.
3. We do not accept voicemails or texts to cancel appointments, please call during business hours to modify appointments.

I have read and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account. I agree that in the event costs and/or fees that are incurred in connection with the collection of my account, I will pay all such costs and fees.

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Print Name of Patient Date

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Signature of Patient or Legal Guardian