Dr. Deborah J. Kim, D.M.D

Williamstown Dental PC

N.J. License #: 17266

375 N Main Street, C-4
Williamstown, NJ 08094
Phone: 856-875-9333
Fax: 856-875-4802

BILLING AND CREDIT POLICY

Thank you for choosing us as your dental healthcare provider. This document states our Billing and Policy. All patients/responsible persons are required to read and sign this document, our Patient Registration and Dental/Medical History forms prior to receiving any treatment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CARE CREDIT & PERSONAL CHECKS (upon approval)

USUAL & CUSTOMARY RATES

We are committed to providing the best dental treatment for our patients. The fees that we charge are usual and customary for our area. You are responsible for the payment in full of all our fees, regardless of any insurance company's arbitrary determination of usual and customary rates.

REGARDING INSURANCE

If we are a participating provider with your insurance plan, we will accept assignment of benefits upon verification of your coverage. All co-pays and deductibles are due and payable at the time service is rendered. If your insurance changes to a plan that we do not participate with, please refer to the following paragraph. Please note: we do NOT participate with any HMO, DMO, or state facilitated dental plans.

If we are not a participating provide with your insurance plan, we MAY accept assignment of benefits. Until that time, payment in full is expected at the time of service.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If we do agree to accept assignment of benefits, we may require payment of 50% of our full fee to be paid at the time of service; the balance will be your responsibility, regardless of whether your insurance company pays in full or not. We also require that you provide us with a credit card and signed authorization to bill that credit card for any balance. If your insurance company has not paid the balance in full within 45 days, the balance due will be transferred to the credit card payment plan.

We cannot bill your insurance company unless you complete and sign the section of the Patient Registration Form that gives us your permission to do so. We also require a copy of the front and back of your insurance card and/or a signed insurance claim form.

Please be aware that some or all of the necessary treatment may not be covered under your individual insurance plan for this reason we require prior determination of benefits by your insurance company for all treatments which total more than $300.00.

Minor Patients: **M**inor Patients will not be treated unless accompanied by a parent or other responsible party who will be responsible for the approval of treatment and the payment of fees.

Missed Appointments: Our Policy is to charge $25.00 per hour scheduled for all missed appointments that have not been canceled at least 48 hours in advance.

[x] **I HAVE READ THIS BILLING/CREDIT POLICY FORM; I UNDERSTAND AND AGREE TO THE TERMS STATED**

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Signature of patient/responsible party Date

Revised: 07/28/2014

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AN EXTENDED PAYMENT PLAN WITH CARE CREDIT CAN BE ARRANGED UPON APPROVAL

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MINOR PATIENTS:

Minor Patients will not be treated unless accompanied by a parent or other responsible party who will be responsible for the approval of treatment and the payment of fees.

Missed Appointments: Our Policy is to charge $25.00 per hour scheduled for all missed appointments that have not been canceled at least 48 hours in advance, with the exception of Saturday and Sunday.

[x] **I HAVE READ THIS BILLING/CREDIT POLICY FORM; I UNDERSTAND AND AGREE TO THE TERMS STATED**

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Signature of patient/responsible party Date

Revised: 07/28/2014