Payment Policy

Thank you for choosing Princeton Center for Dental Aesthetics for your dental needs. We are committed to providing you with the highest quality dental care available. Because patients have had questions regarding insurance we developed this payment policy to aid you in understanding dental insurance. Please read our policy, ask us any questions you may have and sign in the space provided. We will make a copy for your records.

1. Insurance. We participate in some insurance plans. If you are not insured by a plan we participate with, payment in full is expected at each visit. If you are insured by a plan that we do participate with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some of the services you receive may not be covered. You will be responsible for these dental procedures at time of service.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your **driver's license** and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in **30** days, the balance will automatically be billed to you.

7. Nonpayment. A 1.5 % service charge will be added monthly to accounts over 30 days past due. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, your account will be referred to a collection agency.

8. Missed appointments. There is a fee for all missed appointments not canceled **48** business hours prior to appointment time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or call **48** business hours prior to cancel a scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Thank you for respecting our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

______________________________ __________________

Signature of patient or responsible party **Date**