Stephen Family Dentistry, P.C.
1 West Ashland Ave.
Glenolden, PA 19036
Tel: 610-586-0190

Financial Responsibility Policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial responsibility policy.

1. It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **At each office visit** we need you to show us your insurance card to insure that your current insurance information is on file

2. As a service to our patients, we will submit your insurance claim to your primary insurance company . Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy.

3. If a claim is denied, we will research why the rejection occurred an wither resubmit to insurance or bill you the appropriate balance. If the clam is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.

4. If the patient has coverage with a second insurance company, the patient should then submit all secondary claims directly to that insurance company along with a copy of the explanation of benefits from the primary insurance.

5. Insurance is a patient's benefit designed to assist the patient in their financial obligation to Stephen Family Dentistry. The patient is the one receiving the dental service and therefore is ultimately responsible for all charge on the one receiving the dental service and therefore is ultimately responsible for all charge on the account regardless of any insurance coverage. This applies to everyone in the family who is treated by Stephen Family Dentistry.

6. The office will collect the patient's deductible (when services are subject to the deductible) and the estimated balance after insurance at the time services are rendered. After Insurance payment is received the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment.

7. In the event that the patient does not have insurance coverage, charges for services are due and payable at the time services are rendered, unless prior arrangements have been approved.

Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I authorize the dentist to release any information (X-ray, photo picture, molder, personal information etc), including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier my pay less than the actual bill for services, I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any insurance claims not paid within 60 days of service.

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Signature of Patients(parent if minor) or Responsible Party Date