Lyndhurst Dental Associates

3031 Lyndhurst Avenue
Winston-Salem, NC 27103

FINANCIAL POLICY

Thank you for selecting our office as your dental provider. The following is a statement of our financial policy which we ask that you ***read, understand and sign prior to any treatment.***
We are committed to providing you with the best possible dental care and we are happy to discuss our professional fees with you at any time during our normal office hours. Your clear understanding of our financial policy is important to our professional relationship. ***Please ask if you have any questions about our fees, our financial policy, or your responsibility.***
Payment is requested at each appointment as service is rendered and can be made by cash, check, MasterCard, Visa, Discover or American Express. ***Please be aware that if you are a parent bringing a child to our office you are legally responsible for payments on all charges. We cannot send statements to other addresses.***

DENTAL INSURANCE INFORMATION

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. We will only accept this assignment of benefits AFTER you are a patient of record with us. In other words, ***you must pay in full when you first come to our office***. Once we have verified your insurance benefits, we will begin filing your claims for you. ***We estimate what we think it will be and we ask that you pay the remaining balance at the time the services are rendered. Once the insurance company reimburses us, if there is still a balance, you will be billed the remaining portion.***

★ DELTA DENTAL and BCBS of NC SUBSCRIBERS / PATIENTS ★

Our office *does not participate* with any dental company networks therefore Delta Dental *will not* allow assignment of benefits and requires that all insurance payments be mailed to the subscriber. It is our policy in this situation to collect payment in full for any service rendered on the date the service is performed.

You, the patient, are responsible for your entire account balance. If, for some reason, your insurance company does not pay on your claim, you are expected to pay it in full within 30 days of the date of treatment. If your insurance company becomes unduly difficult to deal with, we will ask that you proceed with whatever measures you deem appropriate to collect on your claim. We will use the information provided on the previous form in order to file your claim.

I authorize the release of any information concerning mine or my child's dental care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me and I understand that I am financially responsible for payments in full of all accounts.

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(Please print patient's name here.)

_____ _____
Signature of patient, parent or guardian Date