Scott C. Earp DDS PA
Comprehensive Dentistry & Orthodontics

Please review our financial policy so that we may provide you with optimal dental care.

FINANCIAL POLICY

Our primary goal is to balance the cost of treatment with your dental needs. In addition, we strive to maximize your insurance benefit.

Our fees are based on the quality materials we use and the time, effort and skill required in performing your needed treatment. We charge usual and customary fees for our area. We will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. However, we cannot guarantee any estimated coverage, therefore you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **Because the insurance policy is an agreement between you and your insurance company, we ask that all patients be directly responsible for all charges.** Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment at no cost to you.

We accept the following forms of payment: Cash, Check, Visa, Discover, MasterCard and American Express. Additionally, we offer CareCredit, a patient payment program offering a No Interest/Six Month Payment Plan for treatment fees for $200 or more. Payment for services is due at the time services are rendered unless prior arrangements have been made.

Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee to cover bank administration costs. We encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our practice manager and/or insurance coordinator, at any time to discuss these concerns.

CO-PAYS & DEPOSIT POLICY

Co-Pays and deposits are required before services are rendered. In an effort to protect your privacy and comply with HIPAA we accept payments in the privacy of your treatment room so that your private financial information is not discussed at the reception desk. We offer electronic payment and accept check/cash payments before treatment in your private treatment room.

RESCHEDULING/CHANGE IN SCHEDULE

Our practice is dedicated to quality care and exceptional service. We provide 2-3 appointment reminders via your choice of text, email or phone call if email address and cell phone numbers are provided. Our doctor and team spend an extensive amount of time preparing for your visit. Broken and missed appointments create scheduling problems for our team as well as effects other patients who have been trying to get an appointment**. If you find that you must change your appointment, we require a minimum of 24 hour notice so we may make every effort to accommodate other patients. If proper notice is not received, a fee of $85.00 will be charged to your credit card on file for your allotted time cancelled.**

I have read and agree to the Financial Policy and the Cancellation Policy of Scott C. Earp, DDS PA. I agree to a credit card on file that may be charged for violation of these policies, unpaid balances and co-pay of services rendered.

Credit Card Number____ Exp Date_______________Zip Code_______________

Signature of Patient or Responsible Party____ Date_________________________

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PRACTICE POLICY

LATE PATIENTS

In an effort to avoid significant delays in our office schedule, patients arriving more than 15 minutes late for an appointment may be asked to reschedule or wait for the next treatment opening if available the same day.

SEEING MINOR CHILDREN WITHOUT A PARENT

Children less than 18 years of age are legal minors and will not be seen without parent or guardian consent. Primary guardian is responsible for consent and financial responsibilities of dental treatment; we cannot bill or wait for payment from second party or separation/divorce changes in guardianship. If your child is less than 18 years of age and will be seen for orthodontic check-up or cleaning, please sign consent to see your child here:

I, ____, consent for Scott C. Earp, DDS PA to treat my child, ____ for orthodontics or prophylaxis (cleaning) in my absence. Likewise, Non-guardians that may bring my child to their appointment in my absence are____.

Signed ____ Date ___________________________.

NEW PATIENTS AND EMERGENCIES

We are grateful you chose our practice. Emergency and new patients will be asked to remit payment for their treatment at the time of service unless insurance benefits can be verified. We will file your insurance electronically for you to be reimbursed if verification of insurance is not accessible. Thank you for your understanding of our practice policy.