

Office Financial Policies

Dental Insurance

Insurance filing is a courtesy provided to the patients and is in no way a responsibility of the office.

We will file your primary insurance only. If you have secondary coverage, please let us know if you need superbills in order for you to submit your insurance claims. Children that are covered by two insurance plans generally fall under the "birthday rule" if there are two plans.

Your insurance coverage is determined by what your employer has purchased. Payments for services can vary widely from policy to policy. Some procedures may be denied based on age, pre-existing conditions or length of time on the plan. These restrictions are based on your specific plan as determined by your employer's contract with the insurance company. If you are unsure about your insurance coverage, we advise you to contact your dental insurance carrier for information and clarification about your benefits.

UCR's (usual and customary rates) are applicable only to plans with which we participate (i.e. Delta Premiere – USA and some United Concordia plans).

Delinquent Accounts

Interest in the amount of 1% per month (12% annum) will be charged to all accounts over 90 days past due. In the event that your account is referred to an attorney for collection, the undersigned is required and agrees to pay all court costs plus an amount equal to 1/3 of the unpaid principal as an attorney fee.

Returned Checks

A fee in the amount of \$20.00 will be charged for all returned and "insufficient fund" checks.

Broken and Cancelled Appointments

If you are unable to keep your scheduled appointment, we ask that you give us a minimum of 24 hours notice. If sufficient notice is not given, a charge may be assessed.

By signing below, I certify that I have read the financial policies (stated above) and understand these policies. I agree to abide by the policies above for treatment provided by the practice of Drs. Novick, Hartz, Hall, Novick, Sharma, Martinez and their associates. I certify that all information provided is correct. I hereby authorize the doctors and staff to release personal information to the insurance company for all persons on my account. I understand that the account balance is ultimately my responsibility regardless of insurance coverage and payments. I understand and agree that the terms herein are reaffirmed each time services are rendered.

Signature of Responsible Party

Date

Arthur J. Novick, DDS	Gary L. Hartz, DMD	Robert G. Hall, DDS
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