Advanced Dental Group

528 Street Road
Southampton, PA 18966
215•322•2262

150 West State Street
Doylestown, PA 18901
215•230•4464

PATIENT RESPONSIBILITY AGREEMENT

Patient Initials

I understand and agree that I will be financially responsible for the patient services provided by **ADVANCED DENTAL GROUP** (also called the "Dental Office"), according to the policies stated in this Patient Responsibility Agreement.

TREATMENT PLAN. I acknowledge that I am financially responsible for all patient services including services which may be itemized in a Treatment Plan. The Treatment Plan may be amended or changed from time to time.

PATIENT INFORMATION. The patient information provided to the Dental Office is true and correct. I will notify the Dental Office about any significant future revisions to the patient information furnished including, but not limited to changes in address, marital status and insurance coverage.

INSURANCE. If I expect my insurer to cover some or all of the cost of the patient services, the Dental Office will assist me, as a courtesy, in obtaining the appropriate benefits from the insurer by billing the insurer. This also serves as a release of information to all my insurance companies. I agree to cooperate and provide all information necessary to the Dental Office. However, I have the primary relationship with my insurer and the Dental Office is NOT responsible for guaranteeing that benefits will be received in the amounts and in the time-frame as requested. ***I am responsible to resolve any problems with my insurer.*** I may request that the Dental Office obtain a pre-estimate of Insurance benefits before patient services are performed.

PAYMENT SCHEDULE. Unless my treatment is scheduled over a period of time, and unless I specifically request, and the Dental Office approves in advance a payment schedule for the patient services, ***all payments for services are due when a billing statement is presented after the services are performed.*** The Dental Office will not otherwise approve any deferred payment schedule.

BILLING STATEMENT. It is possible that portions of the bill for patient services, such as co-payments, deductibles and policy exclusions may not be paid by the insurer. The unpaid portions are my responsibility and must be paid by me when a billing statement is presented after the patient services are performed. Payments may be made in cash, check or by credit card. If my insurer has not paid the benefits to the Dental Office within 90 days after submitted, the Dental Office may then require me to pay for the patient services in full, and any insurance benefits later received by the Dental Office will be returned to me or credited to my account for future services, the choice being mine as the patient.

REFERRAL FOR COLLECTION. If my account is referred to an outside agency or attorney for collection after 90 days, I will also be responsible for any and all collection costs, including but not limited to, all attorney's fees, whether contingent or otherwise, and court costs. The Dental Office may deny subsequent patient treatment if my account balance remains unpaid.

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ACCOUNT CHARGES. If my account remains unpaid after 90 days, I can be assessed with additional account charges at the rate of 1 ½% per month (18% annually).

ACCOUNT ADJUSTMENT. If I fail to make a co-payment by the date required by my insurer, if applicable, then my account can be adjusted and I would be responsible for the full amount due for the patient services rendered.

FAMILY RESPONSIBILITY. I am authorized to agree, for myself and on behalf of my spouse (if applicable), to remain financially responsible for all future services rendered to all of my immediate family members including children, regardless of ages, unless I notify the Dental Office in writing otherwise.

COLLECTION FROM OTHERS. If I am financially indigent and unable to pay for patient services rendered, the Dental Office may seek to recover my account balance from certain adult relatives under applicable Pennsylvania law.

CANCELED/MISSED APPOINTMENTS. If an office appointment is canceled with less than 24 hours notice, OR, if I simply fail to show up for a confirmed appointment, I can be assessed with a cancellation fee of Forty dollars ($40.00).

RETURNED CHECKS. Should my check be returned by the bank for any reason, I will be assessed with a processing charge of Thirty-five dollars ($35.00).

PRIVACY PRACTICES. I have received/read a copy of the Dental Office's Notice of Privacy Practices.

We attempted to obtain written knowledge of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

- ❑ Individual refused to sign.
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency situation prohibited us from obtaining acknowledgement.
- ❑ Other (Please Specify _____
  _____

_____ _____

Date Patient or Responsible Party Signature