Dr. Andrea Barrett DDS
(732) 846-2494

812 Hamilton Street
Somerset, NJ 08873

BelBar Dental Assoc.
Dental Office Policy

Patients with Dental Insurance: As a courtesy to you, our office will gladly submit to your insurance. We are able to bill to traditional, indemnity insurance plans. Please check your type of plan carefully. If you have any questions about out-of-network benefits please call your insurance company.

Authorization To Release Info And Assignment of Benefits: I hereby authorize the doctor and/or her staff to release all necessary personal information to my insurance company in order to secure the payment of benefits.

Payments: We accept cash, check, Visa, MasterCard, Discover, American Express, and Care Credit. Please Note if you are paying by check there will be a **$35.00** fee for any bounced check **Plus** it will be your responsibility for any bank fees that apply and we will no longer be able to accept any other personal check. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot **guarantee** the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (100%, 80%, 50% etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you.

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed/or stamped on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past-Due Accounts: If payment is not received by the due date printed/ or stamped on the statement, then your account is considered "**past due**". We reserve the right to charge a **$5.00** per month billing charge on all past due accounts. If the balance is still unpaid after 90 days, the account will turn over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Patients Without Insurance: Payment must be paid in full at the time services are rendered.

Broken/Missed Appointments: We request at least 48 hours' notice before cancelling or rescheduling an appointment. That way, we have some time to try and fill the opening left in our schedule. We reserve the right to charge your account **$50.00** if we are not notified at 24 hours before your appointment. Thank You for assisting us in keeping our schedule full.

Dr. Barrett reserves the right to update and make changes to the above-stated office policies at any time without prior notification.

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered to me and my dependent (If Applicable)

Patient Name (print): _____ Date: _____

Responsible Party Signature: _____ Relationship to patient: _____