MAGNA DENTAL, PC

PATIENT FINANCIAL AGREEMENT

(REVISED 6-18-2020)

PATIENTS WITHOUT INSURANCE:

*PAY IN FULL AT EACH APPOINTMENT

PATIENTS WITH INSURANCE:

*NEW PATIENT-PAY IN FULL DAY OF SERVICE (EXCEPT FOR CLEANING APPOINTMENTS).
*CURRENT PATIENTS PAY 30-50% DAY OF SERVICE (EXCEPT FOR CLEANING APPOINTMENTS).
*BALANCES ARE REQUIRED TO BE PAID IN FULL WITHIN 60 DAYS OF SERVICE REGARDLESS OF INSURANCE COVERAGE.
*WE SUBMIT CLAIMS ONLY AS A COURTESY FOR YOU. IT IS YOUR RESPONSIBILITY TO FOLLOW UP ON ALL UNPAID CLAIMS.
*PRE-ESTIMATES ARE NOT A GUARANTEE OF BENEFITS.

PATIENTS WITH DELTA DENTAL INSURANCE THROUGH THE STATE OF ILLINOIS:

*DEDUCTIBLE HAS TO BE PAID IN FULL AT EACH APPOINTMENT
*YOU ARE RESPONSIBLE FOR THE BALANCE ON YOUR ACCOUNT IMMEDIATELY AFTER INSURANCE HAS PAID
*YOUR ACCOUNT WILL BE TURNED OVER TO OUR COLLECTION AGENCY 60 DAYS AFTER WE RECEIVE PAYMENT FROM DELTA DENTAL IF YOU FAIL TO PAY WITHIN THIS TIME FRAME.
*IT IS YOUR RESPONSIBILITY TO FOLLOW-UP ON ALL CLAIMS TO DELTA AS WELL AS CALLING TO CHECK ON THE BALANCE AND STATUS OF YOUR ACCOUNT
*YOU UNDERSTAND THAT ALL THE COLLECTION RULES LISTED BELOW APPLY TO YOU AND YOUR ACCOUNT
*YOU ARE RESPONSIBLE FOR ALL COLLECTION FEES AS STATED BELOW FOR DELINQUENT ACCOUNTS
*PLEASE REMEMBER WE BILL YOUR INSURANCE AS A COURTESY TO YOU, AND MAGNA DENTAL HAS NOTHING TO DO WITH COVERAGE AND OR BENEFITS. THIS IS BETWEEN YOU AND YOUR EMPLOYER.

COLLECTION-DELINQUENT ACCOUNTS:

*A LATE FEE OF 1.5% PER MONTH WILL BE ADDED TO ALL ACCOUNTS 60 DAYS PAST DUE AND THE ACCOUNT WILL BE SENT TO A COLLECTION AGENCY FOR COLLECTION
*YOU AGREE TO PAY ALL COLLECTION FEES THAT ARE ADDED TO YOUR ACCOUNT INCLUDING BUT NOT LIMITED TO 30-50% COLLECTION AGENCY FEE BASED ON YOUR ACCOUNT BALANCE THAT WILL BE ADDED TO YOUR ACCOUNT BALANCE, REASONABLE ATTORNEY COST, THIRD PARTY EXPENSES, AND COURT COST.

MISC.:

*THE PARENT/GUARDIAN/POA, ETC. THAT BRINGS A PATIENT IS THE ACCOUNT HOLDER FOR THAT PATIENT'S BILLING.
*ALL REFUND CHECKS CAN ONLY BE WRITTEN FOR THE ACCOUNT HOLDER.
*PARENTS/GUARDIANS/POA/ETC. WILL BE REQUIRED TO FILL OUT THE PAPERWORK AND BE HERE FOR THE INITIAL VISIT OF THE PATIENT THEY ARE BRINGING.
*BENNY CARDS/HEALTH SAVINGS/MEDICAL OR DENTAL CARE CREDIT CARDS/PREPAID CARDS: MAGNA DENTAL, PC IS NOT RESPONSIBLE FOR TRACKING, FOLLOWING, UNDERSTANDING AND IS NOT A PROVIDER, CONNECTED, AFFILIATED, OR UNDER CONTRACT. USING YOUR CARD IS TRULY A FORM OF PAYMENT FOR DENTAL SERVICES RENDERED. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE PERIMETERS, BENEFITS, AND LIMITATIONS, OF USING YOUR CARD. THE FINANCIAL POLICY OF MAGNA DENTAL, PC AS EXPLAINED ABOVE SUPERSEDES.

FEES:

$60.00 NSF/RETURN OF PAYMENT FEE, $60.00 NO SHOW FEE WITHOUT A 24 HOUR NOTICE AND
A 4% NON-REFUNDABLE CREDIT/DEBIT CARD PROCESSING FEE IS ADDED TO ALL CREDIT/DEBIT PAYMENTS.

BY SIGNING THIS YOU HAVE READ, AGREE, AND FULLY UNDERSTAND THE ABOVE TERMS AND CONDITIONS.

SIGNATURE OF PATIENT: _____ DATE: _____

(OVER 18 YEARS OF AGE)

SIGNATURE OF PARENT/GUARDIAN/POA
OR CUSTODIAN: _____ DATE: _____