PIERCE & RYAN DENTISTRY

Written Financial Policy

Thank you for choosing Pierce & Ryan Dentistry, PLLC. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:
Cash, Check, Visa, Mastercard or American Express
Convenient Monthly Payment Plans from CareCredit
In-House Discount Plan (Available to patients without Dental Insurance)

Please note: Pierce & Ryan Dentistry, PLLC requires payment prior to the completion of your treatment.

Insurance:

As a courtesy to our patients, our office will file your treatment with your insurance company and accept assignment of insurance benefits, as permitted. Dental insurance benefits are designed to help with some of your basic dental care; however, do not cover all treatment needs. Individual employers negotiate plans that are detailed in your benefits package, if your insurance is provided through an employer. Please note all charges incurred are your responsibility, regardless of your insurance coverage or status. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. We must emphasize that as your dental care provider, **our relationship is with you, our patient, not with your insurance company.**

The majority of dental plans allow for deductibles and co-payments. Payment by the dental plan will be based on the provision of your individual plan; therefore, you will be asked to pay your estimated portion when checking out instead of the full amount due for treatment rendered. You will receive a bill for any balance not paid by your dental plan and it is your responsibility to pay that balance.

We will gladly submit a predetermination to your dental plan upon your request. A predetermination provides a confirmation that the patient is a covered enrollee of the dental plan and that the treatment planned for the patient is a covered benefit at the time the predetermination is processed by your insurance company. It also provides a written estimate from your dental plan of the patient's likely out-of-pocket expenses for the care. A predetermination is not a guarantee of payment, your dental plan will determine payment based on current benefits and plan maximum available to you on the date of service. Please note that all predeterminations have an expiration date and can range from 90 days to 1 year.

Our office will verify insurance eligibility on your first visit of the year. Eligibility, benefits and plan maximums can change at any time. Having dental work completed at another office, changes in your employment status or terminating insurance are some examples of how your benefits may be affected. Any changes to your plan should be shared with our office before your scheduled appointment as this will impact your out of pocket expense.

Cancellation Policy:

Appointments are scheduled on an individual basis, reflecting the amount of time needed to complete specific treatment. We do realize that everyone has busy schedules. If you need to cancel or reschedule an appointment, we ask that you please notify us at least 48hrs in advance. A fee of $75.00 per hour is charged for patients who miss or cancel without a 48-hour notice. We reserve the right to request payment of a missed appointment fee and deposit in order to reschedule a missed appointment. If the appointment is cancelled without a 48-hour notice this deposit will be applied to a cancellation charge.

Pierce & Ryan Dentistry, PLLC charges $35.00 for returned checks.

By signing below, I acknowledge I have read and understand the Written Financial Policy. I authorize Pierce and Ryan Dentistry to file my treatment with my dental insurance company, communicate as needed with the policy holder of my insurance plan and the responsible party on my account and for payment to be sent directly to Pierce & Ryan Dentistry, PLLC. I understand I am responsible for my deductible and estimated copay at the time of treatment as well as any balance left after my insurance has paid.

Patient Name (Please Print): _____

Patient, Parent or Guardian Signature: _____ Date: _____