Financial Policy

Thank you for choosing New Day Dentistry! Our primary mission is to deliver the most comprehensive dental care available, while keeping the costs manageable. Please review our financial policy and talk to our administrative team if you have any questions.

If We Accept Your Insurance Plan: As a courtesy to our patients, we will submit covered services directly to your insurance company and provide information necessary to expedite claim processing. In addition, we estimate your portion of your treatment costs, which will be due in full at time of service, unless other payment arrangements are made in advance with our office. In the event that your insurance company denies, underpays, or delays payment of your claims beyond 90 days, you will be responsible for the remaining balance of the account. Please notify our office if your insurance requires pre-authorization of treatment, as failure to do so may result in a denial of your claims. To ensure proper handling of your claims, please present your insurance card to our administrative team at each visit.

If You Do Not Have Insurance: Payment in full is due at the time treatment is rendered, unless other payment arrangements have been made in advance with our office. We are happy to work with you to receive the care you need. Please ask our administrative team if you have any questions about our Membership plan and/or financing options

- Please be advised, we do not accept personal checks over $500.
- Accepted Payment Methods: Visa, Mastercard, Discover, cash, checks, money orders and CareCredit.
- We are pleased to offer interest-free or extended financing options to our qualifying patients.

Cancelled/Failed Appointments: We value your time and ask for the same consideration. Please provide us with 2-business days notice when making changes to an existing appointment. Late, missed, cancelled or rescheduled appointments without proper notice may be subject to a cancellation fee. This cancellation fee is $50.00 per scheduled hour. Depending on the appointment length, patients who arrive more than 10-minutes late to their scheduled appointment may need to be rescheduled and a cancellation fee may apply. Patients who miss three scheduled appointments may be asked to pay a retainer in order to hold future appointments in our office. Please be mindful of our time and avoid cancelling without proper notice whenever possible.

Collections & Court Costs: If your account is not paid in full on the day of service (or by the due date on your invoice in case of insurance claim denial or underpayment), and you have not made financial arrangements with our office, your account may be turned over to our collections department**.** Accounts transferred to our collections department will be ineligible for any discounts offered and subject to a 40% or $40 collection fee, whichever is greater, as well as court costs and attorney fees, for which you will be responsible. Please contact us immediately if you have questions about an invoice you have received. We always prefer to avoid escalated collection measures and work with you directly to clear your balance.

Additional Fees: In some cases, charges may be made for record duplication and transfers, medical reports, or narratives sent to other practitioners, insurance companies or attorneys at your request. Charges may also be made for lab samples or off-site radiography and imaging ordered by your treating dentist. Returned checks and letters to you requiring certified mail will be subject to a $35 service charge. You will be responsible for these additional fees.

ACKNOWLEDGMENT OF FINANCIAL RESPONSIBILITY: I have read, understand and agree to the terms of this Financial Agreement. I understand that I am responsible to pay in full for services rendered, including reasonable attorney fees and costs of collection in the event of default. I hereby authorize New Day Dentistry PLLC to furnish or obtain any/all information to/from insurance carriers/Social Security Administration, the referring doctor or PCP, physicians, other agencies to whom we refer you, or *designated* next of kin or caregiver concerning treatment. I authorize my insurance company to send payment directly to New Day Dentistry PLLC. My signature below indicates my cooperation and agreement.

_____	_____	_____
Printed Name (Guarantor)	**Signature**	**Date**

HIPAA ACKNOWLEDGMENT: The undersigned has reviewed the Notice of Privacy Practice and agrees to the terms set for in the HIPAA Information & Consent Form. This consent shall remain in force from this time forward. The undersigned further agrees that New Day Dentistry PLLC may make changes as necessary, with or without notice, to reflect updates and changes enforced by The Health Insurance Portability and Accountability and other regulatory agencies.

_____	_____	_____
Printed Name (Guarantor)	**Signature**	**Date**