

**Paul S. Lewis, D.D.S., M.S.**

*Specialist in Periodontics*

## **PAYMENT POLICY FOR INSURED PATIENTS**

In order to avoid misunderstandings regarding payment for services provided at this office, we wish to clearly explain our payment policy. If you have any questions regarding this policy, please let us know.

- Procedures performed in our office are covered under most dental and some medical plans. However, insurance pays only a portion of our fees. There are deductibles and co-payments for which the patient is responsible. Also, your insurance carrier makes payments based upon their own fee schedule which may be different from our usual fees. In most cases, 50% to 75% of the fee is covered by insurance. Therefore, a minimum payment of 25% of the fee is required at the time of service.
- Full payment is required at the time of service for procedures with a fee under \$150.00. Such procedures include:
  - Initial examinations
  - Periodic reevaluations
  - Maintenance cleanings
  - X-raysWe will then submit an insurance claim to your carrier and any payment will be sent to you.
- Patients who make full payment in cash or by check (not by credit card) at the time of service will receive a 5% discount.
- If we do not receive payment from your insurance company within 60 days of the date of service, you will be required to pay the balance. Any insurance payments that we receive after you have paid the balance will be forwarded to you.
- Accounts with balances over \$350.00 which are more than 60 days past due will be assessed a monthly finance charge of 1.5% (18% annually).
- Accounts with balances under \$350.00 which are more than 60 days past due will be assessed a \$5.00 billing service charge.

***Under all circumstances, the patient, not the insurance carrier, is responsible for payment for our services.***

\_\_\_\_\_  
Patient's name

\_\_\_\_\_  
Name of the person who is responsible for the patient's account

**I have read, understand and received a copy of this Payment Policy.**

\_\_\_\_\_  
Signature of the person who is responsible for the patient's account

\_\_\_\_\_  
Date

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