SCOTT F BOBBITT, DMD, MAGD, PA
Scheduling and Financial Agreement

Scheduling & Confirmations:

Making your Appointments with our Providers:

Our Scheduling Manager is available to schedule your dental care needs Monday to Thursday from 8-5pm. Our administrators work hard to coordinate our patient appointments with providers availability. Please call ***603-882-3001*** or email ***admin@drbobbitt.com*** so that we can organize a more predictable schedule for those involved.

How We work with You to Confirm Your Scheduled Appointment:

Our electronic appointment reminder system notifies you of your scheduled appointment in advance thru email and/or text. Please select the CONFIRM button at that time to let us know you are planning to keep that appointment. Should you need to make a change, we ask for at least 2 business days' notice. This allows us time to find you a more suitable appointment as well as time to reach out to others who may be waiting to be seen so we can fully utilize our providers' availability. Should you not confirm through our automated system, we will call you at least 2 days prior to your scheduled reservation in hopes of securing your reply. No carrier pigeons……

"No-Show" Appointments:

Life happens, work demands change, however, if you are aware of a scheduling conflict, please call us. If a patient fails to cancel the appointment with proper notice of at least 2 business days or fails to attend, this is considered a "No-Show" event and will be documented as follows:

- A Grace/Goodwill Courtesy of $60 will be applied to your account to the first "No-Show".
- A Subsequent hygiene "No-show" appointment will be assessed a $60 per hour fee.
- A Subsequent doctor "no show" appointment will be assessed a $150 per ½ hour fee.
- Extenuating circumstances will be taken into consideration for unexpected personal tragedy or a state mandated state of emergency due to severe weather.

Financials:

If the Responsible Party for this account is NOT yourself, please complete the following:

Name of Responsible Person: ________________________________ **Relationship to Patient:** ___________

Cell phone: (   ) _________________ **Address** (if not the same as patient)**:** _____________________________________

Driver's Lisc #: ________________________ **DOB:** _____________ **SSN:** _________________________________

Payment for Services Rendered:

- Please come prepared to make payment for services rendered.
- All insurances are individually set up by the subscriber's employer with a dental benefits carrier. We ask your assistance in being familiar with your plan: Plan maximums, calendar or fiscal year, exclusions, coverage %, waiting periods, etc. is instrumental for understanding that there may be times when a procedure isn't a covered service or a claim is denied. Should this occur, you are ultimately responsible for the payment of services rendered regardless of how your carrier handles your insurance claim.
- Should you have us submit a claim to your carrier, we expect your estimated copayment be made prior to or on the day services are rendered regardless of insurance coverage. We do our best to give you an **educated estimate** but cannot guarantee coverage. Once your claim is adjudicated, we will send a statement for any balance due.
- Should your account carry a credit, accounts are reviewed monthly for credit checks to be sent out accordingly.
- A patient's and/or guarantor's social security number must be on file to carry any credit in our office.

Methods of Payment, *Please check the method you prefer:*

- ☐ **Online Payment**
- ☐ **Credit Cards**: Health Savings Acct, Debit, Major Vendors (VISA, MasterCard, Discover, American Express)
- ☐ **Cash**
- ☐ **Personal Check**

Accounts Department Services:

- **Statements:** Payment is requested no later than due date listed on your statement.
- **Electronic Insurance Claim Service :**
  - ☐ Provide current dental benefits card prior to arriving to your appointment so we have enough time to contact your carrier to ensure correct insurance data is on file
  - ☐ Processed in conjunction with your **estimated** Copayments

- **Payment Plans *Arranged in Advance* for Treatment:** Our Accounts Manager can help to find options to fit most budgets, however, it is important to make those arrangements IN ADVANCE of your scheduled appointment not after.
- **3rd Party Financing *Arranged in Advance* for Treatment:** Short (interest free) and long term (interest bearing) budget payment plans available through 3rd Party Financing Companies, **www.CareCredit.com**, or **www.BeWell.com.** Applicants are subject to credit approval. Please discuss this option with our Accounts Manager.
- **Layaway Payment Plan *Arranged in Advance* for Treatment:** Got a great credit history with our office? This option may be for you. Down payments prior to scheduling treatment with 3 or 4 month interest free options can be pre-arranged. Communication is key with this arrangement. All payment plans MUST be arranged **in advance** with the Accounts Manager.
- **Senior Citizens (age 65+) Courtesy:** Non-Insured Seniors are eligible for a 10% courtesy under the following criteria: Accounts must hold no balance, Cash or Check payment in full for same day services, this courtesy cannot be combined with any insurance, courtesy, or any other offer.

When payments are not received on time:

Should financial obligations not be met, it is important you contact our Accounts Manager in a timely manner. The key is COMMUNICATION so we may help find a resolution. We reserve the right to assess the following fees and charges:

- **Late Fee**: assessed when payment is not received by the due date on your statement or payment agreement.
- **Finance Charge:** Periodic Rate of 2% per month or 24% APR (Annual Percentage Rate) is automatically assessed to any balances aged to 60+ days from the date of service regardless of insurance benefits/delayed claim, or payment plans that are not fulfilled.
- **Returned checks:** A returned bank check for non-sufficient funds will be assessed a minimum of $40 to the account.
- **Delinquent Accounts:** It is critical should you not be timely in payment, you reach out to our Accounts Manager. We reserve the right to submit any account past 90 days to a collection agency with the addition of a 35% collection service fee. Submitting your account to a collection agency will report you to the 3 credit bureaus and will sever the doctor/patient relationship you and any associated family members have in our office.

Please present your picture ID card or driver's license for identification purposes and any dental insurance cards to our administrators.

Dental Insurance:________________________________**Policy ID#:** ____________________

Telephone # 1-800 ______________________ **Subscriber Name:** ________________________

DOB: _____________ **SSN:** _______________**Subscriber Employer:** ____________________

Patient's Relationship to Insured: ❍ **Self** ❍ **Spouse/Partner** ❍ **Child/Dependent** ❍ **Other**

Authorization, Release and Signature on File:

- I take the responsibility to keep my personal contact and insurance information on file up to date prior to my arrival for my scheduled appointment.
- I am authorized and grant permission to your or your assignee to communicate with my by telephone/email/fax between 8am-9pm at work or home to discuss matters related to my care.
- I have read the Appointment Reservation and Payment for Services and understand my obligation as a patient of record with the office.
- My Signature on File authorizes the office, Scott F Bobbitt, DMD, PA to discuss treatment recommendations, referrals, process claims, including any information regarding the diagnosis, treatment records rendered during the period of such services provided to third party payers and or other health practitioners.
- I hereby authorize payment of the insurance benefits for services rendered, otherwise payable to me, to the professional corporation: Scott F Bobbitt, DMD, PA

Printed Name:	**Signature:**	**Date:**