Financial Policy

We share your concerns regarding the increasing cost of health care. We believe that you, our patients, expect and deserve the highest quality care we can provide at a reasonable cost. While we take advantage of every possible avenue to keep costs down, we are committed to not sacrificing quality for less expensive care. With this in mind, we would like to share some information with you about our financial policy. We want you to feel comfortable with us regarding your financial and insurance matters and thereby prevent any misunderstanding. We hope you will consult with us if you have any questions regarding our services and our financial policies.

Many people who have insurance think that the insurance company owes the doctor for services, not the patient. Please keep in mind that any insurance contract is between the patient and insurance company. Therefore, the patient is responsible for the bill, regardless of insurance coverage. As a courtesy to our patients, we are happy to bill your primary insurance for you. However, the responsibility for payment remains with the patient (or insured).

Patients With Insurance. At the time of treatment, patients are requested to make an initial payment toward the estimated charges. This amount will be based upon benefit information obtained from your insurance company, including but not limited to your deductible. If your insurance pays in addition to the balance due on your account, a refund will be sent to you. These refund checks are sent out once per month.

Many insurance plans state that you will be covered up to "50%, 80%, or 100%." In spite of that statement, we have found in actuality that many plans may cover less than that depending on their established "usual and customary" when setting fee limitations on services. Please be aware that some insurance companies will pay a claim percentage based on their "usual and customary fees," not our actual charges. To determine exactly what portion of your bill will be covered by insurance, we will gladly request pre-authorization by your carrier. However, this may require up to four weeks to be processed by the insurance company.

Patients Without Insurance. Patients without insurance are required to pay the charges at the time of treatment, unless other arrangements are established.

Charge Cards. Visa, MasterCard and Discover may be used for payment on your account.

Patient Financing. We participate in programs that allow patients to finance their treatment through third party lenders. If you are interested in this service, please ask the financial coordinator.

Checks. There will be a $25.00 charge for all returned checks.

Account Balances. Balances on all accounts are due in full in 60 days regardless of insurance coverage or anticipated payment from other sources. If payment for our services is not made within 60 days, an interest charge of 5% per month will be added to the account. Therefore, patients with insurance whose claims have not been paid within 30 days should contact their insurance company to determine the reason for delay of payment. Delinquent accounts will be referred for collections at the discretion of the financial coordinator.

Assignment and Release. For individuals with insurance, your signature below hereby authorized your insurance benefits to be paid directly to the doctor. You are sill financially responsible for any balance due. It also authorized the doctor to release any information required for payment and processing of this claim.

Notification. I realize that once an appointment is made, I have reserved that time slot in the schedule. If I fail to give adequate notice (more than 12 hours), I may be charged a minimum of $25 and a maximum not to exceed $100 per hour of appointment time reserved. I have read and understand the above financial information. The financial arrangements have been discussed with me. I accept financial responsibility for the procedures to be performed. I also understand that if I default on payment and can't be resolved with Dr. Tad Lovan, I will also be charged service charges that will be greater than or equal to any court costs, attorneys' fees, collection agency fees, and/or any other costs associated with collection any incurred debt. A copy of this signed agreement has been provided to me.

X _____

Signature of Patient, Parent or Legal Guardian

X _____

Date

X _____

Witness