Financial Policy

Effective Nov 2022

Thank you for choosing Eleisha J Nickoles, DDS, PLLC. We are dedicated to providing the best possible dental care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the financial policy, please do not hesitate in discussing them with us.

Full payment is due as services are provided.

For minor patients, parents or guardians who accompanies the child is responsible for payment at the time of service. For your convenience, we accept credit card (Visa, MasterCard, Discover, American Express), debit card, cash, and check payments. Please note that should a check bounce, there will be a $60 fee charged to your account. We offer Care Credit for 3rd Party financing for dental procedures not covered by your insurance plan OR for patients who have no insurance plans and need to finance. Special financing options with convenient monthly payments are available with the CareCredit healthcare credit card.

For treatment services equaling over $500:

50% of that cost will be required as a deposit at the time of booking the appointment(s). Please note that this deposit is non-refundable should the appointment be cancelled/rescheduled without two business days' notice. At the conclusion of your appointment, you will receive a statement outlining the services that were performed.

Missed Appointments:

Time reserved in the schedule is valuable to us and all our patients who require dental care. In order to maintain excellent service, we require that you make a change to your reserved time at least two business days in advance. We reserve the right to charge $50 if notice is not given for a missed appointment.

Returned Checks & Past Due Accounts:

Any returned checks may be turned over to a collection agency. You will be responsible for any additional collection fees and/or legal charges. In the event that your account is placed in the hands of an attorney for the collection of any balance owed to Eleisha J Nickoles, DDS, PLLC you will be responsible also for legal fees and costs incurred in any legal proceeding. You understand if this account is submitted to an attorney or collection agency, you may be subject to litigation in a court of law. Your past due status may be reported to the credit bureaus or become a matter of public record. Once an account has been sent to collections, any future appointments will be canceled. Once the account is made current, you may still remain a patient of the practice, however, you must pay in full on the date of service going forward.

If You Have Dental Insurance:

If you request that we bill your insurance for your visits, we require to have a Credit Card on file. There is no additional charge or fee for this service. If you are unable to provide us with a valid Credit Card, you are responsible for full payment of your dental treatment at each visit. We can still submit your dental claim to your insurance provider OR provide you with a dental insurance claim form that you can submit to your insurer or employer.

- We understand how important your dental benefits are for you and your family. We consider these benefits your prepaid dental treatment.
- Dental insurance rarely covers 100% of the services provided. Check your plan(s) for details regarding your dental benefit.
- Although we cannot guarantee the amount of insurance payment, we will always submit claims to your insurance company.

We require a current copy of the front and back of your dental insurance card(s). If your insurance does not provide cards, we need the policy holder's employer, date of birth, and social security number to be able to submit to your insurance company on your behalf. PLEASE UNDERSTAND that your benefits are a contract between you and your insurance company. We are a third party to that contract, and it is completely your responsibility to be aware of what your coverage is. As a courtesy to you, our office provides certain services, including a pre- treatment estimate which we will send to the insurance company only at your request. If you are having trouble finding out what you're

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covered for feel free to ask us for help. Important Information if we are direct billing your insurance company:

- You are required to pay any portion not covered by insurance on the day of the appointment, or when response is received from your insurance provider.
- You are responsible to know the details of your dental insurance coverage, and any limitations your plan may have. Due to privacy laws, we are unable to access your insurance coverage information on your behalf.
- The electronic insurance responses are an estimate provided by your insurance provider and are subject to change until the time we receive payment for your treatment.
- Please be aware that there will be a 25% deposit taken the day of the appointment if the insurance company does not give us a breakdown of coverage.
- Please note that your insurance provider can change your coverage at any time. Therefore, you should be reviewing your policy and keeping track of any notification from your employer regarding any changes to your insurance coverage.
- If we are unable to bill your insurance for any reason, or if there is any outstanding balance on your account, you are responsible for bringing the account up-to-date immediately and we will be charging the balance to the credit card on file below.
- We will not charge your credit card without notifying you if the outstanding balance is over $500 after payment from insurance has been received. Once payment has been processed a receipt will be provided to you by email.

If you have dental insurance, would you like us to direct bill to your insurance?

Yes No

If you do NOT have dental insurance, would you like to keep a credit card on file?

Yes No

If Yes, complete below. Please present the credit card you enter below at your first appointment. Update us if this card changes.

Card Type:

Visa Mastercard AMEX Discover Care Credit

Card Number

Name on Card

CCV # (On back)

Expiry MM

Expiry YY

List the names of all the patients you give us permission to use this credit card for:

I have read, understood, and agree to the above terms and conditions. I authorize Eleisha J Nickoles, DDS, PLLC to bill the above Credit Card for any balance on my account under the above conditions.

First & Last Name

Email Address

Signature

x

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