Robert A. Milner, D.D.S Dental Corporation
27725 Santa Margarita Parkway, Ste. 120
Mission Viejo, CA 92691
(949) 859-8899

Financial Agreement Policy

Please initialize each paragraph

A Word About Insurance: As a courtesy to all patients we will verify your dental insurance benefits, but you are responsible ***to know your plan coverage, exclusions and limitations***. Furthermore, you should be aware of non-covered benefits such as a missing tooth, crown/bridge/denture restorations, bruxism, downgraded limitations for fillings and porcelain on crowns on molar teeth, frequency limits for exams, prophylaxis (cleaning,) fluoride and x-rays, etc. _____ **(Please provide your initials)**

The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check; and we also accept most major credit cards. To help you accept an extensive treatment plan, we currently offer the CareCredit® Dental Treatment Financing Program. All estimates provided are subject to final approval by your dental insurance plan; therefore, the amount due is subject to change after final explanation of benefits has been paid. _____ **(Please provide your initials)**

Initial Payment for Dental Treatment: Most plans are covered for routine clinical exams and prophylaxis, in most cases a deductible is not due for diagnostic or preventative treatment unless stated otherwise in your plan. There are some plans with coinsurance payment for x-rays and dental exams. Deductibles for basic/major services customarily include fillings, crowns, extraction, root canal therapy, and periodontal treatment. Some plans do not allow separate benefits for crown build-up. In such cases the patient is responsible for the full cost of a build-up. _____ **(Please provide your initials)**

Implant Pre-Surgical Treatment: Pre-Payment is required at the time of scheduling appointment for implant placement, full payment of balance is required at the time of implant placement. _____ **(Please provide your initials)**

SCRT (Deep Cleaning Treatment): Pre-payment is required at the time of scheduling appointment with the doctor or hygienist. _____ **(Please provide your initials)**

Resin-Based Composite Restorations (Fillings): Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars.) The plan benefit will customarily pay for a less expensive treatment (amalgam or silver/mercury-based restoration. Robert A. Milner, D.D.S. Dental Corporation *only* places composite-based (white) fillings. The patient is responsible for the difference in cost between the amalgam and composite rates.
_____ **(Please provide your initials)**

Pulp Cap Treatment (Medicament to Protect Pulp Chamber): Most dental plans do not allow additional benefits for pulp cap treatment (this procedure is where the filling is very deep and the nearly exposed pulp is covered with a protective medication to help with healing via formation of secondary dentin.) Pre-payment of the cost of this treatment is paid at the time of treatment and is the patient's responsibility. If your insurance does not cover this treatment or does not allow separate benefits, you shall be charged the contracted fee as agreed upon between our office and your insurance carrier (Robert A. Milner, D.D.S. Dental Corporation is a preferred provider of most major insurance plans.) _____ **(Please provide your initials)**

Financial Charges: All returned checks are subject to $35 service charge, plus a $5 redeposit fee. All balances over thirty (30) days are subject to finance charges at 19% per month as mandated by State Law. Robert A. Milner, D.D.S. Dental Corporation reserves the right to apply a $20 rebilling fee and a $25 late charge toward overdue financial agreements per month. If your account is forwarded to our outside collection agency due to nonpayment, Robert A. Milner, D.D.S. Dental Corporation reserves the right to report your balance with us to any credit reporting agency and/or credit bureau.) _____ **(Please provide your initials)**

Past Due Accounts: In the event that your account is turned over to our collection agency, you agree to pay all fees including and not limited to attorney fees, court costs and collection agency fees. _____ **(Please provide your initials)**

Missed Appointment Fee: Please be advised that there is a missed appointment/cancellation of appointment fee of $50 per hour for all appointments not given at least three (3) business day prior notice of appointment date. ***Appointments are not to be cancelled via a voicemail message left on the practice telephone recording***. Patients are to call in advance if there is a need to reschedule or cancel an appointment. _____ **(Please provide your initials)**

Transferring Records: A written request is required if you would like us to mail, fax, e-mail, etc., any part of your record with Robert A. Milner, D.D.S. Dental Corporation. We require at least eight (8) working hours prior notice to prepare your records for transfer. Further, three (3) business days shall be required if your record is more than two years old and has been placed in archive. The cost of duplication/printed x-rays is $50 per single periapical x-ray (PA), $15 for bitewing x-rays, $25 for full-mouth x-rays (FMX), and $25 for a panoramic (pano) film. Copying and printing fees are $10 per record. The fee shall be waived if Robert A. Milner, D.D.S. Dental Corporation is referring you to a specialist. _____ **(Please provide your initials)**

Robert A. Milner, D.D.S Dental Corporation
27725 Santa Margarita Parkway, Ste. 120
Mission Viejo, CA 92691
(949) 859-8899

Dental Insurance Claim Processing Policy

Because of the economic climate the business of collecting on claims with dental insurance companies has become increasingly difficult. We, therefore, have been forced to establish a policy which removes Robert A. Milner, D.D.S. Dental Corporation form a place of constant confrontation with our patients.

It is your dentist's responsibility to recommend the treatment that you require. All recommendations are based on diagnostic (X-rays) and clinical photographic images and presented to you by your dentist or by the practice manager. Your dentist will give you options (if available) for the treatment recommended and shall be glad to answer all questions you may have regarding the recommended treatment and shall assist in the decision as to what treatment would be the best for you.

If you carry a supplemental or secondary insurance plan, we will assist you with both insurance claims. However, we still will follow our policy to collect deductible, coinsurance and pre-payments. An overpayment, if applicable, shall be returned or applied to future treatment only after the secondary claim has cleared, in the form of payment and/or non-payment. _____ **(Please provide your initials)**

If you are interested in following the doctor's recommendation and need to know **exactly** how much your insurance plan will pay for the recommended treatment, a pre-authorization estimate will need to be filed with your carrier. Robert A. Milner, D.D.S. Dental Corporation shall file a patient treatment pre-authorization to your primary carrier **upon the patient's request** before the treatment is initiated. However, it should be noted that this may delay your treatment by six to eight weeks to await he response from your insurance carrier. _____ **(Please provide your initials)**

For patients requesting pre-authorization, which require digital images and study models, there will be a $100 service charge at the time of the initial appointment. This will insure that Robert A. Milner, D.D.S. Dental Corporation recoups financial loss if the patient decides against proceeding with treatment. If the patient does proceed with the treatment, the $100 service charge will be credited toward the "patient pays" portion, thereby reducing the patient's financial obligation. _____ **(Please provide your initials)**

Robert A. Milner, D.D.S. Dental Corporation will send a dental claim on your behalf and shall answer any questions your insurance carrier may raise about diagnosis or treatment in an appropriate, timely manner. ***It is important that you understand that we are not a party to the relationship between you and your insurance carrier. If your insurance carrier denies benefits for treatment for any reason, the patient shall be held financially responsible for all charges and for any outstanding balance on the account. Robert A. Milner, D.D.S. Dental Corporation is unable to "compel" an insurance company to fulfill its obligation to you. If the insurance carrier does not pay for your treatment in a reasonable period of time, a patient shall be held responsible to pay the balance on the account. All credits (if provided) shall either be placed toward your future dental treatment or returned at your request.*** _____ **(Please provide your initials)**

It is our goal here at Robert A. Milner, D.D.S. Dental Corporation to assist our patients in any way possible to assist you in proceeding with your recommended dental treatment plan by providing support with your benefits. While we are here to help, this is not meant to construe in anyway our assuming total responsibility for the decisions of your insurance carrier which may affect the patient financially. _____ **(Please provide your initials)**

This is an Agreement between Robert A. Milner, D.D.S. Dental Corporation, as a provider of professional services and the creditor, and the patient/debtor as indicated below. By reading and signing this Agreement, you are approving and accepting this policy in full. _____ **(Please provide your initials)**

I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION; ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND AND AGREE TO ALL POLICIES OF THE ROBERT A. MILNER, D.D.S. DENTAL CORPORATION.

Printed Name of Patient/Subscriber/Guardian	**Signature**	**Date**
Printed Name of Witness	**Signature**	**Date**