WAYNE T. KINNEY, D.D.S., P.C.

2828 E. 96th STREET • INDIANAPOLIS, INDIANA 46240 • 317-575-1120

TO MY PATIENTS:

In order to avoid misunderstandings regarding payment of fees, this is our office policy. **All patients are expected to take care of their fees at the time services are rendered.** You are responsible for payment of your account within the limits of our credit policy.

We will accept the following methods of payment in this office:

1. **CASH/CHECK**
2. **CHARGE CARDS/DEBIT CARDS**: MasterCard, Visa, Discover, American Express and Care Credit (6 months) are available for our patients who need to extend payments.
3. **INSURANCE**: Patients who have dental insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. As an out-of-network provider we do accept all insurance and file the claims at no extra charge.

You have three choices of payment when insurance is involved:

1. When paying in full by cash/check, insurance benefits will be paid directly to the patient.
2. We will accept assignment of benefits; however, the deductible and coinsurance are due at the time services are rendered. Delta Dental are typically sent to the subscriber, so payment is appreciated at the time of service.
3. You may leave an HSA or credit card number on file with us. We will then submit your insurance to pay us directly. Your signature below allows us to run your credit card for any balance on your account and mail a statement and your credit card receipt to you.

PLEASE CIRCLE YOUR OPTION OF CHOICE.

For patients covered by Delta Dental, the payment will be sent to you. You may select option 1 and pay in full at the time of service. As a courtesy, we may allow you to endorse the check (immediately upon receipt) and send to us, while paying your portion at the time of service

FEDERAL TRUTH IN LENDING INFORMATION

I understand that there will be a charge of 1.5% per month (18% per annum) for any unpaid balance over 60 days. If payment is not received from the patient within sixty (60) days, the patient will be responsible and liable for all collection of attorney costs incurred while enforcing collection of said account.

_____ _____

Date Patient Signature/Parent or Guardian if minor

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INSURANCE INFORMATION AND AUTHORIZATION

This office is happy to help you process your insurance. We will complete our portion of the claim form and mail the form promptly and at no charge.

We include patients with insurance in our normal monthly billing routine.

Insurance coverage usually is limited to a portion of the fee agreed to by you in our office. There categorically is no such thing as a "UCR" fee for any nation, state or zip code that is not created internally by the insurance industry. The limits of your coverage are based upon such things as premium amounts and profit margins designed by the insurance company. The insurance companies are solely responsible for those numbers.

We are not members of any networks/groups, nor do we agree to any fee schedules other than those agreed to between you and this office. When you receive treatment in this office, you agree to be financially responsible for the entire fee in this office, independent of insurance coverage. All insurance fees are only estimates and we do not accept responsibility for insurance exclusions or coverage. We advise you to become familiar with your insurance benefits.

☐ I authorize payment of benefits directly to the provider.

☐ I authorize the release of all necessary information to the insurance carrier and their representatives.

☐ I have read this form and agree to be financially responsible.

Date Patient Signature/Parent or Guardian if minor