**Brafman Family Dentistry, P.A.**
**31381 Dogwood Acres Road, Unit 2**
**Dagsboro, DE 19939**
**Phone: 302-732-3852 Fax: 302-732-3855**

**Kevin H. Brafman, D.D.S.** **Wendy Wilson Brafman, D.D.S.**

# Financial Responsibility Policy

As a result of the many different and confusing insurance company reimbursement policies, it is necessary to have an easily understood financial responsibility policy.

- It is important for you to provide the office with complete insurance information for all carriers with whom you are insured at the time of service. **At each office visit** we need you to show us your insurance card to ensure that your current insurance information is on file.
- As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive maximum benefit from your insurance company. **However, it is the patient's responsibility to know the insurance coverage and benefits limit of their particular policy.**
- If a claim is denied, we will research why the rejection occurred and either resubmit to insurance or bill you the appropriate balance. If the claim is denied a second time, the appropriate balance immediately becomes the responsibility of the patient and should be paid to us directly. You may then contact your insurance company for reimbursement.
- If the patient has coverage with a second insurance company, the office as a service to the patient will submit the secondary claim form along with a copy of the explanation of benefits from the primary insurance to the secondary insurance company. In the event that the primary insurance company pays you and not us, it is the patient's responsibility to provide Brafman Family Dentistry, P.A. with the Explanation of Benefits (EOB) from the primary insurance company in order to submit to secondary insurance for payment, as the EOB is a requirement for submission of secondary claims.
- Insurance is a patient's benefit designed to assist the patient in their financial obligation to the office of Brafman Family Dentistry, P.A. The patient is the one receiving the dental service and therefore is ultimately responsible for all charges on the account regardless of any insurance coverage. This applies to everyone in the family who is treated in the office of Brafman Family Dentistry, P.A.
- **The office will collect the patient's deductible and the estimated balance at the time of service.** After the primary insurance payment is received, the patient will be billed for any difference between the anticipated insurance payment and the actual insurance payment. If the insurance payment is greater than the estimation, we will either refund the amount to the patient or leave the credit balance on the patient's account to be applied toward any future treatment.
- In the event that the patient does not have insurance coverage, charges for services are due and payable at the time services are rendered, unless a signed financial agreement has been approved.

Insurance benefits are estimates only. I understand that I am responsible for any co-payments and deductibles, along with any procedures that my insurance company does not cover. I authorize the dentist to release any information, including diagnosis and records of treatment rendered to my family, or me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered and any collection fees accumulated on my behalf or that of my dependents. I am also responsible for any insurance claims not paid within 60 days of service.

Brafman Family Dentistry, P.A. reserves the right to charge a monthly billing fee and to use a Collection Agency for the collection of an account and will charge that account any collection fees involved. If we must initiate legal action to collect amounts due, you agree to pay pre and post judgement interest, court costs, and attorney's fees, as allowed by the law and the court.

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Signature of Patient (parent if minor) or Responsible Party Date