MAGNA DENTAL, PC

PATIENT FINANCIAL AGREEMENT

(REVISED 12-15-2023)

PATIENTS WITHOUT INSURANCE:

PAY IN FULL AT EACH APPOINTMENT

PATIENTS WITH INSURANCE:

NEW PATIENT-PAY IN FULL DAY OF SERVICE (EXCEPT FOR CLEANING APPOINTMENTS). CURRENT PATIENTS PAY 30-50% DAY OF SERVICE (EXCEPT FOR CLEANING APPOINTMENTS). BALANCES ARE REQUIRED TO BE PAID IN FULL WITHIN 60 DAYS OF SERVICE REGARDLESS OF INSURANCE COVERAGE. WE SUBMIT CLAIMS ONLY AS A COURTESY FOR YOU. IT IS YOUR RESPONSIBILITY TO FOLLOW UP ON ALL UNPAID CLAIMS. PRE-ESTIMATES ARE NOT A GUARANTEE OF BENEFITS.

PATIENTS WITH DELTA DENTAL INSURANCE THROUGH THE STATE OF ILLINOIS:

THE DEDUCTIBLE HAS TO BE PAID IN FULL AT EACH APPOINTMENT (EXCEPT FOR CLEANING APPOINTMENTS). YOU ARE RESPONSIBLE FOR THE BALANCE ON YOUR ACCOUNT IMMEDIATELY AFTER INSURANCE HAS PAID. YOUR ACCOUNT WILL BE TURNED OVER TO OUR COLLECTION AGENCY 60 DAYS AFTER WE RECEIVE PAYMENT FROM DELTA DENTAL IF YOU FAIL TO PAY WITHIN THIS TIME FRAME. IT IS YOUR RESPONSIBILITY TO FOLLOW-UP ON ALL CLAIMS TO DELTA AS WELL AS CALLING TO CHECK THE BALANCE/STATUS OF YOUR ACCOUNT. WE BILL YOUR INSURANCE AS A COURTESY TO YOU. MAGNA DENTAL HAS NOTHING TO DO WITH YOUR COVERAGE AND OR BENEFITS AND IS BETWEEN YOU AND YOUR EMPLOYER.

COLLECTION-DELINQUENT ACCOUNTS:

A LATE FEE OF 1.5% PER MONTH WILL BE ADDED TO ALL ACCOUNTS 60 DAYS PAST DUE AND THE ACCOUNT WILL BE SENT TO PAB COLLECTION AGENCY FOR COLLECTION. YOU AGREE TO PAY ALL COLLECTION FEES THAT ARE ADDED TO YOUR ACCOUNT INCLUDING BUT NOT LIMITED TO 30-50% COLLECTION AGENCY FEE BASED ON YOUR ACCOUNT BALANCE THAT WILL BE ADDED TO YOUR ACCOUNT BALANCE, REASONABLE ATTORNEY COST, THIRD PARTY EXPENSES, AND COURT COST. YOU UNDERSTAND THAT THE COLLECTION RULES APPLY TO YOU AND YOUR ACCOUNT. IF YOU ARE A CURRENT OR PRIOR COLLECTION ACCOUNT YOU ARE REQUIRED TO PAY FOR SERVICES IN FULL AT EACH VISIT.

MISC.:

THE PARENT/GUARDIAN/POA/ETC. THAT BRINGS A PATIENT IS THE ACCOUNT HOLDER FOR THAT PATIENT'S BILLING. ALL REFUND CHECKS CAN ONLY BE WRITTEN FOR THE ACCOUNT HOLDER.
PARENTS/GUARDIANS/POA/ETC. WILL BE REQUIRED TO FILL OUT THE PAPERWORK AND BE HERE FOR THE INITIAL VISIT OF THE PATIENT THEY ARE BRINGING. BENNY CARDS/HEALTH SAVINGS/MEDICAL OR DENTAL CARE CREDIT CARDS/PREPAID CARDS, MAGNA DENTAL, PC IS NOT RESPONSIBLE FOR TRACKING, FOLLOWING, UNDERSTANDING AND IS NOT A PROVIDER, CONNECTED, AFFILIATED, OR UNDER CONTRACT. USING YOUR CARD IS TRULY A FORM OF PAYMENT FOR DENTAL SERVICES RENDERED. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE PERIMETERS, BENEFITS, AND LIMITATIONS, OF USING YOUR CARD. THE FINANCIAL POLICY OF MAGNA DENTAL, PC AS EXPLAINED ABOVE SUPERSEDES. PAYMENT PLANS ARE NOT OFFERED. ALL LAB CASES MUST BE PAID IN FULL BEFORE DELIVERY. MAGNA DOES NOT PROVIDE A MONEY BACK GUARANTEE FOR ANY SERVICES THAT IT PROVIDES. ALL LAB CASES MUST BE DELIVERED WITHIN A TIMELY BASIS DEEMED ESSENTIAL FOR ITS PROPER FIT. YOU WILL BE RESPONSIBLE AND BILLED FOR THE BALANCE DUE, IT CANNOT BE LEFT IN OUR LAB FOR ANY LENGTH OF TIME.

FEES:

$60.00 NSF/RETURN OF PAYMENT FEE. $60.00 NO SHOW FEE WITHOUT A 24 HOUR NOTICE.

BY SIGNING THIS YOU HAVE READ, AGREE, AND FULLY UNDERSTAND THE ABOVE TERMS AND CONDITIONS.

SIGNATURE OF PATIENT: ______________________________ DATE: ________________

(OVER 18 YEARS OF AGE)

SIGNATURE OF PARENT/GUARDIAN/POA
OR CUSTODIAN: ______________________________________ DATE: ________________