HOWARD L. EDELMAN, D.D.S.
JAMES M. STEVENSON, D.D.S.

Dresher Professional Center
830 Twining Road, Suite 9
Dresher, Pennsylvania 19025
Telephone: (215) 641-0441

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our provider-patient relationship. If at any time you have any questions or concerns regarding our fees, financial policy, or your responsibilities please feel free to contact us.

If you do not have insurance, proof of insurance, or participate in a plan that will not honor an assignment of insurance benefits, **payment is due at the time of service.**

We accept cash, checks, Visa, Mastercard, Discover and Carecredit. A $35.00 service fee and any additional bank fees incurred will be charged for all returned checks.

The parents or guardians of unaccompanied minors must make arrangements for payment of professional services **prior** to the time of the visit.

Please remember that your insurance policy is a contract between you and your insurance carrier. We will bill your insurance and help you receive the maximum benefit under your policy. We do expect patients to be interactive and responsible for communicating with your insurance carrier on any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. It is the patient's responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. **When insurance is involved, we are contractually obligated to collect co-payments, co-insurance, and deductibles as outlined by your insurance carrier on the day of service. You are responsible for timely payment of your account.**

Please be aware that out-of network insurance carriers may prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable/customary or usual/prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor, are responsible for all out-of-network fees.

I have read and understand the above financial policy. I agree to assign insurance benefits to Dr. Edelman and Steveson whenever applicable.

Responsible Party Signature _____ Date_____