Kirk M. Zeger, DMD
General Dentistry

110 E. Franklin Street Greencastle, PA 17225 717.597.2507

NOTICE OF FINANCIAL RESPONSIBILITY

Our fees are meant to be fair and reasonable. We strive to keep them that way. You can assist us in this effort by providing payment for your visit on the date of service. Prior to your visit, our staff can assist you with estimating the fees for your appointment with our office.

We will offer complete information to all insurance carriers covering services to our patients. Dr. Zeger assumes no responsibility should a patient (Parent or guardian, if minor) err in the utilization of their insurance for reimbursement, according to their insurance company rules, regulations, limitations and requirements. It is important to understand that in most cases, the insurance carrier will REDUCE your cost not ELIMINATE it. You are responsible to our office for the FULL amount of the services rendered, regardless of the reimbursement amount provided by your insurance carrier. Please note that most dental insurance providers reimburse the patient directly, therefore payment is due at the time of service.

Patients with insurance are expected to pay an estimated co-pay baed upon a percentage of the total charge at the time of service. Any insurance payment not received within 60 days after filing the claim for service will become the financial responsibility of the patient. Payment is expected within 10 days of notification of unreimbursed amounts.

If your account is outstanding for more than 60 days after notification, it will be turned over to a collection service and additional fees will be assessed.

Any check returned to our office for non-payment is subject to additional fees payable to our office. Immediate remittance in the form of cash, money order or certified funds is expected.

I consent to the use and disclosure of the patients protected information for treatment, payment and healthcare operations. I do assign insurance benefits to be paid to Dr Kirk M. Zeger that would otherwise be payable to me.

If at any time you have a question about this policy or your account, please do not hesitate to contact our office manager. I have read the above policy and agree to accept financial responsibility.

Signature
Patient/Guardian:_____ Date:_____