FINANCIAL POLICY FOR JOHN E. VILLANO, DDS, PC

In the interest of good healthcare practice, it is necessary to establish a credit policy to avoid misunderstandings. Please carefully review the following:

- If you have no insurance coverage, payment is due at time of treatment. We accept cash, checks, Visa, Discover Card, MasterCard and Care Credit. Outside financing is available through Care Credit and can be applied for by phone (800 365-8295) or internet (carecredit.com) and approved in as little as 10 minutes.
- Health insurance is billed as a courtesy to our patients when complete and accurate billing information is provided at time of service (or within 60 days). WE DO NOT ROUTINELY CHECK YOUR INSURANCE COVERAGE OR BENEFITS. We cannot always know about your coverage, deductible, pre-authorization or policy limitations. Please take the time to know your policy. We will provide an estimate of coverage, but we cannot guarantee the payment amounts or coverage. **It is our policy to collect 20% of the total or your estimated patient co-insurance at time of service.** We will refund you if you over-pay. We may have to bill you for additional payment if your insurance does not pay 80%.
- We will *not* be responsible for waiting on third party liability claims such as auto or homeowners. We will bill them and assist you in collecting, but you must keep your account current during the process.
- You will receive monthly statements from us so long as your account has a balance, *regardless of any pending insurance claims*. You are responsible for payment of your account if your insurance does not pay. Accounts accrue interest at a rate of 1.5% per month or 18% annum after 90 days, regardless of pending insurance claims.
- It is your responsibility to know if your insurance requires a “referral” or pre-authorization and make arrangements to obtain that in advance.
- **We are not contracted to bill claims to MEDICARE or MEDICAID / Oregon Health Plan. Medicare and/or OHP patients who wish to be treated in our office are responsible for payment of their services.**
- Accounts with a balance after 90 days may be referred to a collection agency after mailing you notice.
- A $25.00 fee will be charged for any returned checks.

I have read and understand the financial policy. I agree to be financially responsible for my account.

Patient Name (PRINTED): _____

Responsible party, if the patient is a minor (printed): _____

Signature of patient or responsible party: _____Date: _____