PerioPartner, P.A. 625 E. Nicollet Blvd., #330 Burnsville, MN 55337

Financial Policy

At PerioPartner we are committed to providing you with the best possible dental care. We are willing to discuss our professional fees related to your recommended treatment at any time. Your understanding of our financial policy is important to our professional relationship.

Initial Visit

All patients referred to our office must undergo a Comprehensive Oral Exam with our Periodontist. Dental x-rays may be required to provide a proper diagnosis of your condition. Please check that your referring dentist(s) has shared all current x-rays with our office, prior to your appointment. The fee for a Comprehensive Oral Exam (D0180) is $215 and if needed, a Complete X-ray Series (D0210) is $164, of which payment is required at the time of your first visit.

Dental Insurance

We will assist you by processing all dental insurance claims. It is the patient's responsibility to understand their insurance benefits, out-of-pocket expenses, and if our office is outside of your dental insurance network. As a courtesy, we process your dental claims and pre-treatment estimates, after your initial exam. A pre-treatment estimate from your insurance company is not a guarantee of coverage. The guarantor and/or patient will be personally liable for all balances not covered by dental insurance. Our office is a provider for most Delta Dental PPO & Premier (excluding Group 216) and HealthPartners. We do not accept medical assistance insurance. Please be aware that we cannot submit medical insurance claims or workman's comp claims. All correspondence with medical insurance is the patient's responsibility. If you contact your medical insurance about possible medical benefits, we can assist you with any dental treatment codes and x-rays.

Payments

Payments are required at the time of treatment. For insured patients, we collect your estimated out-of-pocket fee on the date of service. If insurance has not provided us with a pre-treatment estimate prior to your treatment, you will be required to pay in full at the time of your treatment. You will be reimbursed when insurance pays. We accept cash, check, Visa, Master Card, Discover and American Express. We do not accept payment plans. The State of Minnesota requires a 1.8% Healthcare Tax be added to all treatment.

Care Credit

PerioPartner accepts payment through Care Credit. Care credit is a 6 month, interest-free, credit card program, for charges over $600, pending credit approval by application to Care Credit. Please contact one of our treatment coordinators to review this program or visit www.carecredit.com.

Past Due Accounts

Finance charges will be imposed on accounts beginning 30 days from the date of the initial billing statement. We charge a monthly 1.5% service charge or a $3.00 handling fee (whichever is greater) on all past due accounts until they are paid in full. Overdue accounts may be referred to a collection agency or handled by staff, and any legal fees, collection costs or court fees, and service charges that apply will be added to your account and become the patient's responsibility.

Missed Appointments

Specific time has been reserved for your treatment in our office. Therefore, we request advance notification of cancellations. If it is necessary to cancel your appointment, please notify us at least 3 business days in advance to help serve our patients better. Patients 20 minutes late for a scheduled appointment may be considered an appointment failure unless there are extenuating circumstances. For late cancellations/missed appointments, we reserve the right to charge:

- $125 fee for recalls, $180 for root planning scheduled with a hygienist
- $115 for consultations and $200/hour for treatment scheduled with Dr. Glover & his periodontal assistant

I understand and will comply with the above financial policies of PerioPartner. Please ask us about any terms of the financial agreement that is unclear to you. We are here to help you with your periodontal and dental implant needs.

Patient/Guardian Signature: _____ **Date:** _____

Patient/Guardian Name (Print): _____