

**Angela S. Evanson, D.D.S., P.C.**

**Terms and Conditions**

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. Please initial the following provisions indicating that you understand our terms and conditions.

\_\_\_\_\_ I understand, as a courtesy to me, Dr. Evanson will complete insurance information forms and submit claims on my behalf to my insurance company; however I will not hold Dr. Evanson responsible for the outcome of the transactions.

\_\_\_\_\_ I agree to sign any necessary assignment documents that may be required by my insurance company that instructs my insurance company to make payments directly to Dr. Evanson.

\_\_\_\_\_ I agree to pay the estimated copayment, which is the amount not covered by my insurance company, at the time of service. (The copayment is only an **estimate** of charges and may be found to be insufficient after reviewed by the insurance company).

\_\_\_\_\_ I agree to submit payment in full if my insurance company does not pay within 60 days from date of service and therefore I will be responsible for seeking reimbursement from the insurance company.

\_\_\_\_\_ I understand that if my insurance company denies any or part of the service performed, I will be responsible for paying the balance.

\_\_\_\_\_ I understand that Dr. Evanson will not dispute any outstanding claims with my insurance company on my behalf. It will be my responsibility to resolve any type of dispute over payments made or not made by my insurance company.

\_\_\_\_\_ I understand that predetermined rates are NOT a guarantee of payment by my insurance company.

**In addition to the provisions regarding my insurance I also agree to the following terms set forth by Dr. Angela Evanson:**

\_\_\_\_\_ I understand that I will provide at least 48 hours notice to change my appointment otherwise it will be considered a missed appointment.

\_\_\_\_\_ I understand that I will be required to pre-pay a deposit to schedule an appointment if I miss 2 or more appointment is a 12-month span.

\_\_\_\_\_ I understand that a service charge of 1.5% per month will be charged on unpaid balances for all accounts exceeding 60 days unless written financial arrangements are made.

\_\_\_\_\_ I understand that my account may be turned over to a collection agency for non-payment or delinquency. I will be responsible for payment of any and all collection costs, attorney fees, and the balance owed. All accounts turned over to a collection agency forfeits any past special fees or discounts.

\_\_\_\_\_ I understand that there is an "After-hours" fee for any emergencies that are required after normal working hours.

\_\_\_\_\_ I understand that any controlled substance drug (ie: Valium) prescribed to me will place my name on Prescription Drug Monitoring Program or PDMP.

I have read and understand the terms and conditions set by the office of Dr. Angela Evanson

Patient's name (please print): \_\_\_\_\_

Patient signature \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Guardian: \_\_\_\_\_