PROSTHO. ENDO.
Bethesda | Rockville | Vienna

DJ Shin, DMD, MS
Ana Kim, DMD

Phone: 301-377-8306
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hello@prostho-dent.com
www.prostho-dent.com

Patient Financial Policy and Agreement

We are committed to providing you with the best possible care and helping you receive maximum insurance benefits. You need to understand your insurance coverage: not all services are covered by all plans and we do not know the details of all insurance plans. While the filing of insurance claims to insurers that we participate with is a service that we extend to our patients, all fees are ultimately the patient's responsibility. We accept assignments from most major insurance carriers; which means covered charges will be paid directly to us. We file secondary insurance with Trusted Doctors participating insurance carriers only. You will be held responsible for all services provided to you, with or without insurance benefits.

If we do not participate with your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file your dental claim on your behalf to the insurance company. However, payment is expected at the time service is rendered. ***Insurance companies may send you the reimbursement check made out to you directly via mail, please do not deposit the check and forward the check along with the explanation of benefits (EOB) to our office. Failure to do so may result in accrual of fees.***

While we strive to obtain the most accurate information on insurance benefits and coverages for each patient, it is ultimately your responsibility to be aware of your insurance benefits. Discrepancies may arise between the estimated coverage and the actual coverage when claims are processed by your insurance provider, and in the event of any discrepancies, you will be responsible for any remaining balances owed to Prostho Endo Dental Specialists. If there is a refund to be processed, we make every effort to refund you within 30 days of being aware of the discrepancy. By signing this form, you authorize Prostho. Endo. Dental Specialist to securely store your credit card information for the sole purpose of charging or refunding any remaining balances that may result after processing insurance claims for the dental services you receive.

In the event that your saved credit card information is invalid and/or there are outstanding payments after three collection attempts, we will engage the services of a collection agency, which may adversely affect your credit score. Should the account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for all applicable collection agency fees of 35%, interest at 18% per annum, and any and all applicable court costs.

If refunds are due and your credit card information is invalid, we will mail a check to your mailing address on file, and it is your responsibility to ensure that your mailing address is up to date. The following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the family's account, and there are no outstanding patient balances on the family's account. Please note that you have the option to make payment or receive refunds by other means if you choose. You have the right to revoke this consent at any time by notifying Prostho. Endo. Dental Specialist in writing.

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Due to current federal and insurance regulations, all co-payments, co-insurance, and deductibles are collected at the time of service. We accept cash, checks, AHC, MasterCard, Visa, Discover, and American Express.

Payment plans are extended to families with financial needs. Each agreement is unique and personalized to each family's situation and is arranged through our billing office.

WE ENCOURAGE YOU TO CONTACT OUR BILLING OFFICE PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT 301-377-8306

Additional Fees:

- $25.00 - Co-payments not paid within 24 hours of service
- $50.00 - Checks returned by your bank
- $75.00 - Missed Appointment, not cancelled within 24 hours
- $125.00 - Broken Appointment, appointment missed without notification
- $324.00 - After hour office visits
- $50.00 - Letter Requests
- Collection Fees
- Copies of Medical Records

I hereby authorize Prostho Endo Dental Specialists, Shin Prosthodontics LLC and/or AK Endodontics LLC, to apply for benefits on my behalf for all services rendered. I certify the information I have provided regarding my insurance coverage is correct. I further authorize the release of any and all information necessary for my insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to Shin Prosthodontics LLC and/or AK Endodontics LLC, on my behalf.

I understand and agree regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read the above Financial Policy and have provided Prostho Endo Dental Specialists with true and correct insurance information. I agree to the secure storage of your credit card information by Prostho Endo Dental Specialists. I will notify Prostho Endo Dental Specialists of any changes in my dental insurance coverage.

A copy of this may be used in place of the original.

Printed Name of Patient or Legal Guardian:_____
Signature of Patient or Legal Guardian: _____
Date of Signature: _____