FINANCIAL POLICY OF DRS. STRULL & STRULL, PSC

Drs. Strull & Strull
4122 Shelbyville Rd. Suite A
Louisville, KY 40207
502-896-4401

Drs. Strull & Strull
325 N. Walnut St.
Seymour, IN 47274
866-896-4401

Full payment is due at the time of service for all patients without insurance OR *proof* of insurance. WE WILL NOT BILL YOUR INSURANCE UNLESS YOU PROVIDE A CURRENT INSURANCE CARD.

We will give you a fee that is expected to be paid the day of service. You may pay by cash, check or credit card. If you need financing, we offer Care Credit. Please request details from our finance manager.

If you have insurance and provide us all the proper information, we are happy to file insurance claims for you and we accept assignment of benefits on most insurance plans. If you would like us to file insurance for you, you will be responsible for the following:

Payments due at the time of DENTAL service are:
a. Percentage not covered by your insurance
b. Deductible
c. Any amount over your maximum
d. Any fees not covered by your insurance

Payments due at the time of MEDICAL service are:
a. Co-pay
b. Deductible
c. Any fees not covered by your insurance

Our contract with insurance companies include:

1. **We do not file medical insurance for dental procedures, i.e. tooth removal, wisdom teeth, etc..., nor do we take the "write off".**

2. **Full charges for the services not covered by you insurance are your responsibility, meaning if insurance does not pay on a service, we do not take the "write off".**

If you would like a list of codes and fees written out we will be happy to give this to you. However, the quote that we give you is just an *ESTIMATE* based on the benefits we receive from your insurance company. There is NOT a guarantee, by your insurance company or us that your insurance company will pay. You may have a remaining balance, after insurance is billed and pays their portion, which is your responsibility.

You may request a written Pre Determination be sent to insurance, but these are not routinely done. It can take up to 4-6 weeks to receive these back from the insurance company. Again there is NOT a guarantee of payment by your insurance company, even if we receive something in writing from you insurance.

Some dental insurance require that medical insurance be filed before they will pay on services. In this case WE DO NOT file the medical insurance for dental procedures. We will give you the necessary information for you to file it. *HOWEVER* you must provide a copy of the denial within 30 days to us in order for us to file you dental insurance or the balance of your account will be due by you. Again, a "write off" will NOT be taken on the medical insurance.

Our expectations of you as the owner of the insurance policy include:

1. **Present our office with *ALL CURRENT* insurance information, including mailing address.**
2. **Any charges considered cosmetic or not medically necessary will be your responsibility and will be due in full at the time of service.**
3. **You are responsible for payment if the insurance company does not pay our office within 30 days. Once you have received a second statement, you need to call your insurance and then contact us or your account will be turned over to collection.**
4. **Keep our office informed of any changes in your insurance coverage or employment.**
5. **Realize that it is your responsibility to contact your referring physician for all necessary referrals that are required by your insurance company.**

OVER

*****PLEASE REMEMBER, YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THAT CONTRACT.***

PLEASE NOTE
ACCOUNT BALANCES PAST
60 DAYS WILL BE CHARGED
INTEREST AT THE RATE OF 1.5%
MONTHLY (18% APR)

PLEASE READ THE FOLLOWING AND SIGN BELOW:

1. **Adult Patients accept full responsibility for the payment of their own account as described above.**

2. **Minor patients MUST be accompanied by a parent or legal guardian each visit. The parent/legal guardian accompanying the minor to the first visit will be assigned as guarantor on the account, accepting full responsibility for payment of the minor's account. This may not be the person who carries the insurance. We will not bill former spouses or non-custodial parents without a full copy of a court order indication such person is fully responsible for medical expenses.**

3. **Although this practice may file an assigned clam to my insurance carrier on my behalf, this action does not resolve my financial responsibilities. I understand that if insurance does not pay I will be responsible for payment in full on my account.**

4. **I understand that interest may be charged on accounts placed for collection at a rate of 1.5% a month or 18% a year.**

5. **Consent to telephone calls. If at any time I provide a telephone number at which I may be contacted, I consent to receive calls or text messages including but not restricted to communications regarding billing and payment for items and services unless I notify the office to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology or by electronic mail, text messaging or by any other form of electronic communication from the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.**

6. **Consent to email usage. If at any time I provide my email address at which I may be contacted, unless I notify the office to the contrary in writing, I consent to receiving communications regarding billing and payments for items and services at the email address for the office, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.**

I hereby authorize Drs. James and/or Gregory Strull to release to my insurance company information acquired in the course of my dental and/or medical care. I hereby authorize benefits to be paid directly to Drs. Strull and Strull, PSC. I understand I am responsible for any unpaid balance.

_____
Name of Patient

_____ _____
Signature of Responsible Party **Date**