JASON A. COHEN, D.D.S., P.C.
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The Chevy Chase Building
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Chevy Chase, MD 20815
T (301) 656-1201

PATIENT FINANCIAL TERMS & CONDITIONS

ALL DENTAL SERVICES ARE THE PATIENT'S RESPONSIBILITY REGARDLESS OF INSURANCE COVERAGE. OUR OFFICE WILL BILL YOUR INSURANCE COMPANY ONE (1) TIME ONLY BASED ON THE INFORMATION *YOU* PROVIDE TO THE OFFICE. ALL ACCOUNTS ARE COMPUTER GENERATED AND TURNED OVER TO A BILLING AGENCY AFTER (1) ONE CYCLE. ANY ACCOUNT THAT IS NOT PAID IN FULL WITHIN THE (60) SIXTY DAY GRACE PERIOD WILL AUTOMATICALLY BE SENT TO COLLECTIONS, UNLESS OTHER SPECIFIC ARRANGEMENTS ARE DISCUSSED.

We are committed to providing you with the best possible care and service. If you have dental insurance, we are happy to assist you to receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy. Unless this practice is *a participating provider* with your insurance plan, it is ultimately your responsibility to pay the provider for the services rendered and to assure that your insurance properly processes your claim and pays the provider. It is your responsibility to fully understand the terms and conditions of your insurance regarding the procedures of the filing of claims, what dental procedures and treatments your insurance does and does not cover, what amount, if any, your insurance will pay and what your portion of the payment may be.

Unless otherwise agreed upon by the provider, payment is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

The undersigned patient understands and agrees that it is personally responsible for payment of the bill for the services rendered. However, should this matter be turned over to our attorney for collection, the undersigned understands and agrees to pay pre-judgment and interest in the amount of 18%/year, reasonable attorney fees which are defined as 30% of the principal and any unpaid interest, and all fees and additional costs, including the actual service costs to serve any legal process up to $100.00, and up to $25.00 of additional expenses incurred by the Practice, in order to collect such remaining balance and late fees, which shall be borne by the undersigned. Returned checks shall be subject to a $55.00 bad check fee and a $75 charge may also be made for broken appointments and appointments canceled without 48 hours advance notice.

We will gladly discuss your proposed treatment and charges and will answer any questions relating to your insurance and/or statement. You must realize that unless we are a participating provider with your insurance:

1. *Your insurance is a contract between you and your insurance company. We are not a third party contact and are not bound by their terms.*
2. *We are not bound by the fee payment structures of your insurance policy. Should there be a portion of your statement that your insurance does not pay, you are ultimately responsible for that portion.*
3. *Not all dental services are a covered benefit with some dental insurance contracts. Some insurance companies will arbitrarily select certain services they will and will not cover. These charges are ultimately your responsibility.*

Our relationship is with you and not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.
If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We will be happy to help.

By my signature, I indicate that I have read, understand and do hereby accept the terms of this agreement.

Signature_____

Print Name _____ **Date** _____

JASON A. COHEN, D.D.S., P.C.
NANCY KIESEL, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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