MASON & MASON
DENTISTRY PA

Payment and Fee Policy

We would like to welcome you to our dental practice and to explain our policy regarding fees. We can better serve our patients when there is complete understanding and mutual cooperation.

1. If you do not have dental insurance, full payment is expected at the time services are performed.
2. Because of increased costs of filing insurance and delays in payment, we ask for a copay at the time of service. We accept cash, check, Mastercard, Visa, Discover and American Express.
3. We will gladly file your primary dental insurance as a service to you. The amount of copay is contingent on insurance coverage. Once we receive your Explanation of Benefits you are responsible for any amount not covered by your insurance. You will receive statements by mail with any balance on your account. ***Realize that ultimately you, not your insurance carrier, are responsible for the full fee.***
4. If you have two insurance plans, we will be glad to file with your primary carrier. We will also file your secondary insurance immediately after your primary pays. However, if payment is not received within 30 days after primary insurance pays, we will expect payment in full on your account.
5. A word about insurance: We will not let any insurance company dictate inferior treatment. We will suggest what we think is the best treatment for each patient. We do not make treatment recommendations based on what an insurance plan covers or doesn't cover. It is the *patient's decision* whether or not this treatment is what they desire.
6. If you would like to make extended payments, we offer the convenience of a credit account through a lending institution. If this is of interest to you, please let us know before services are rendered. An application can be filled out online. Please inquire to a team member.
7. We reserve time specifically for your appointment. This is done out of respect for your time. We request the same show of respect if you are unable to keep an appointment by giving us *24 hours of notice* for cancellations. If appointments are cancelled or rescheduled without 24 hours' notice there may be a charge to your account.

IF AT ANY TIME you have questions or a concern about any treatment, fee, or service please discuss it with us promptly and openly. We would greatly appreciate this and will strive to make your relationship with us a pleasant one.

Dr. Ted O. Mason

I UNDERSTAND AND AGREE THAT REGARDLESS OF MY INSURANCE STATUS, I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY PROFESSIONAL SERVICES RENDERED. I HAVE READ ALL OF THE INFORMATION ON THIS SHEET AND HAVE COMPLETED MY PATIENT REGISTRATION SHEET. I CERTIFY THIS INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR PATIENT REGISTRATION INFORMATION.

*Please Print Patient's Full Name:_____

Signature of Responsible Party:_____ Date:_____