DAVID A. LESTER, DDS, PC
2834 CRESCENT AVENUE
EUGENE OR 97408-7397
(541) 686-9372

PAYMENT POLICY ACKNOWLEDGEMENT

IF YOU HAVE DENTAL INSURANCE **NO** FEE ADJUSTMENT IS GIVEN. WE SIGN A DISCLAIMER ON EVERY INSURANCE FORM THAT STATES: I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THAT THE FEES SUBMITTED ARE THE ACTUAL FEES I HAVE CHARGED AND INTEND TO COLLECT FOR THOSE PROCEDURES.

FOR PATIENTS AGE 62 & OVER WITH **NO** INSURANCE A 5% COURTESY ADJUSTMENT WILL BE GIVEN FOR ALL SERVICES WHEN PAID IN FULL BY CASH OR CHECK THE SAME DAY OF SERVICE. NO FEE ADJUSTMENT WILL BE GIVEN IF YOU PAY BY DEBIT OR CREDIT CARD OR IF A STATEMENT IS SENT.

- **A.** ALL VISITS REQUIRE PAYMENT IN FULL BY CASH, CHECK OR BANK CARD UNLESS INSURANCE IS IN EFFECT (*REFER TO B*). EMERGENCY VISITS ALSO REQUIRE PAYMENT IN FULL AT TIME OF SERVICE UNLESS INSURANCE IS IN EFFECT.
- **B.** FOR PATIENTS WITH INSURANCE WE ACCEPT PAYMENT FOR YOUR FIRST VISIT FROM INSURANCE FOR THE PERCENTAGE THE COMPANY WILL ALLOW. WE GLADLY ACCEPT INSURANCE ASSIGNMENTS, BUT REQUIRE THE DEDUCTIBLE AND CO-PAYMENT AND NON-COVERED PROCEDURES BE PAID AT EACH VISIT. IN THE EVENT OF DUPLICATE PAYMENT YOU WILL BE REIMBURSED. ALL DEDUCTIBLE/CO-PAYS OR CO-PAYS ARE JUST AN **ESTIMATE**.
- **C.** BANK CARDS – WE ACCEPT MASTERCARD, VISA AND DISCOVER.
- **D.** OUR OFFICE POLICY ALLOWS $100.00 FOR A BROKEN APPOINTMENT FEE IF LESS THAN 48-HOUR RESCHEDULE NOTICE. VOICE MAIL IS AVAILABLE 24 HOURS PER DAY, 7 DAYS PER WEEK FOR YOU TO LEAVE ADVANCE NOTICE TO CANCEL OR RESCHEDULE AN APPOINTMENT. **PATIENT/RESPONSIBLE PARTY MUST INITIAL HERE:**___________________
- **E.** PROVIDING OUR OFFICE WITH YOUR SOCIAL SECURITY NUMBER IS OPTIONAL, HOWEVER, IF NOT PROVIDED, PAYMENT CANNOT BE MADE BY PERSONAL CHECK. ONLY CASH WILL BE ACCEPTED.

FOR MAJOR SERVICES (ANY SERVICE INVOLVING LABORATORY WORK-CROWNS, BRIDGES, PARTIALS, DENTURES, ETC.) THE PROCEDURE FEE OR INSURANCE CO-PAYMENT IS PAYABLE WHEN TREATMENT BEGINS.

WE ALSO OFFER CARE CREDIT INTEREST FREE OPTIONS AND LOW FIXED RATE PLANS WHICH OFFER FLEXIBLE MONTHLY PAYMENT OPTIONS. PLEASE INQUIRE WITH THE FRONT OFFICE STAFF.

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE DENTAL CARE. OUR FEES REFLECT OUR PROFESSIONAL COMMITMENT TO EXCELLENCE. IT IS IMPORTANT THAT YOU REALIZE…

1. YOUR DENTAL INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER, AND THE INSURANCE COMPANY. WE ARE NOT A PARTY TO THE CONTRACT. OUR OFFICE FILES INSURANCE CLAIMS AS A COURTESY TO YOU.
2. OUR FEES GENERALLY, BUT NOT NECESSARILY, FALL WITHIN THE USUAL AND CUSTOMARY ALLOWANCES DETERMINED BY YOUR INSURANCE CARRIER.
3. YOU (NOT THE INSURANCE COMPANY) ARE RESPONSIBLE TO DR. DAVID LESTER FOR ALL FEES FOR SERVICES RENDERED TO YOU.
4. FOR PATIENTS WHO HAVE INSURANCE, AN **ESTIMATE** WILL BE GIVEN FOR THE BENEFITS EXPECTED FROM YOUR INSURANCE COMPANY AND CO-PAYMENT IS PAYABLE AT TIME OF SERVICE (REFER TO ACCOUNT BALANCE LIMITS ABOVE). WE RECOMMEND A PRE-AUTHORIZATION FOR SERVICES THAT EXCEED $300. **IT IS YOUR RESPONSIBILITY TO CAREFULLY KEEP TRACK OF YOUR INSURANCE MAXIMUM BENEFITS USED AS WELL AS THE TYPE OF BENEFITS YOU HAVE AVAILABLE.** WE HAVE INFORMATION AVAILABLE TO YOU FOR BENEFITS PAID TO OUR OFFICE, BUT IT IS IMPOSSIBLE FOR US TO KEEP TRACK OF ALL OUR PATIENTS' MAXIMUMS. PLEASE CHECK WITH YOUR INSURANCE COMPANY AT ANY TIME. THEY WILL HAVE THE MOST CURRENT INFORMATION AVAILABLE. IF YOU HAVE DENTAL SERVICES PERFORMED BY A REFERRAL DENTAL OFFICE, WE DO NOT HAVE ACCESS TO THE BENEFITS PAID TO THAT OFFICE.

WE WILL GLADLY DISCUSS YOUR PROPOSED DENTAL TREATMENT AND ANSWER ANY QUESTIONS YOU MIGHT HAVE AS TO THE INVOLVEMENT OF YOUR DENTAL BENEFIT PROGRAM IN RECEIVING THIS CARE. WE APPRECIATE THE OPPORTUNITY TO SERVE YOU. THANK YOU!

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SIGNATURE OF PATIENT/RESPONSIBLE PARTY (THIS SIGNATURE WILL SERVE FOR ALL PATIENTS ON THE ACCOUNT.)   **DATE SIGNED**

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PLEASE PRINT PATIENT/RESPONSIBLE NAME ON THIS LINE

Revised 02-25-2010