**Office Policies**

Insurance Policy:

NTDS is in-network with all major PPO insurance companies, **EXCEPT** United Concordia.

Upon verifying your benefits, we will provide an estimate prior to your treatment. Please note, it is not guaranteed that your insurance will cover the treatment as estimated.

In the event you have limited coverage, you will be responsible for any charges and/or fees billed to your insurance company where payment is denied.

Medical Denials:

* Medical insurance will cover some oral surgeries, as some medical conditions may entitle you to dental coverage under your health insurance.
* Some dental insurance policies require that you bill the medical insurance company first, and once that claim is processed you can file a claim toward dental insurance.**This is when a Medical Denial is required.**
* **To ensure your treatment can be done in a timely manner, we will collect for any procedure that requires medical denial up front.**
* **Upon request, we will provide the medical claim form for you to submit to your medical insurance carrier. Once you submit the medical claim form, the explanation of benefits (EOB) will be mailed to you. When you have received your EOB, send us a copy, and we will submit it to your dental insurance carrier on your behalf.**
* **Patient initial: \_\_\_\_\_\_\_\_\_**

 **Predeterminations:**

* **A predetermination (pre-d) of benefits is a review of your proposed treatment plan by your dental insurance. Your dental insurance will determine if they agree with your treatment plan that we have recommended for your dental needs.**
* **Predeterminations are done prior to your treatment, to ensure you understand what is covered vs what is not covered by your dental insurance plan.**
* **Patient initial: \_\_\_\_\_\_\_\_\_**

Payment Policy:

For your convenience, NTDS accepts that following forms of payment:

* Debt cards
* All major credit cards (Visa, Master Card, and American Express)
* Care Credit
* Greensky
* Lending USA
* Check
	+ **Please note, NTDS must receive all checks AT LEAST 5 business days prior to your surgery. NTDS requires the FULL amount to clear the bank prior to the date of your surgery.**
* Patient Initial: \_\_\_\_\_\_\_\_\_\_\_\_\_

Deposit Policy:

NTDS will collect the following deposits upon scheduling your surgery. Please note, all deposits will go towards your total treatment amount.

* All on 4:
	+ Day of scheduling impressions:
		- One arch: $6,200
		- Two arches: $12,400
	+ Day of scheduling surgery: balance is due in full
* All other surgeries: **Remaining balances for the below surgeries are due in full the day of surgery.**
	+ Implants: $200
	+ Wisdom teeth: $200
	+ Frenectomy: $200
	+ Gingivectomy: $200
	+ SRP (deep cleaning): $200
	+ Expose & Bond: $200
	+ Uncover: $200
	+ Incision & Drainage: $200
	+ Crown Seat: $200
	+ Impressions: $200
	+ Tissue Graft: $300
	+ Osseous: $300
	+ LANAP: $300
* Friday surgeries will require the payment due in full at the time of scheduling.
* Patient initial: \_\_\_\_\_\_\_\_\_\_\_\_\_

Rescheduling Policy:

* All on 4:
	+ All on 4 surgeries must be rescheduled **AT LEAST 7 calendar days in advance.**
	+ Rescheduling an All on 4 surgery less than 7 calendar days in advance, is subject to the following non-refundable office fees:
		- 7 calendar days or less = $500 for arch or $1000 for two arches
* All other surgeries:
	+ Surgeries scheduled Monday – Thursday must be rescheduled **AT LEAST 3 calendar days in advance.**
* Rescheduling a Monday -Thursday surgery (i.e. wisdom teeth, implants, extractions, etc.) less than 3 calendar days in advance, is subject to the following non-refundable office fees:
	+ Rescheduling one time =$100
	+ Rescheduling two times = $200
	+ Rescheduling three times = NTDS will no longer accept you as patient
* Surgeries scheduled on Fridays must be rescheduled AT LEAST 7 calendar days in advance.
* Rescheduling a Friday surgery (i.e. wisdom teeth, implants, extractions, etc.) less than 7 calendar days in advance, is subject to the following office fees.
	+ 7 calendar days or less = $200 non-refundable office fee
* Patient initial: \_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read, understand, and agree to NTDS’s Insurance Policy, Payment Policy, Deposit Policy, and Rescheduling Policy. I understand failure to abide by these office polices could result in cancellation of my treatment and procedure.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (minor patients): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_