Andrea H. Folatko D.D.S., Inc.
444 Graham Rd., Cuyahoga Falls, OH 44221
Phone (330)923-9944, Fax (330)923-4949

FINANCIAL POLICY AND RESPONSIBILITY AGREEMENT

Welcome to the dental office of Dr. Andrea H. Folatko and thank you for choosing us as your dental care provider. We are committed to providing you and your family with a safe and relaxing environment, while treating your dental care needs. The following explanation is intended to promote a better understanding of our financial policy and to develop a comfortable relationship between you and our staff. Prior to starting any treatment, you are required to read and sign this policy.

Payment for Services

Payment in full is due at the time services are rendered. If you have insurance, your estimated co-insurance and deductible are due at the time services are rendered.

- We accept the following forms of payment: cash, check, money order, Visa, MasterCard, Discover, and Care Credit
- If dentures, partial dentures, crowns or bridges are to be made by a dental laboratory, a deposit of half of the patient responsibility will be required at the time of the first appointment. The remaining balance is due at the time the prosthesis is delivered.
- Checks that are returned to our office from your financial institution are subject to a $35.00 returned check fee. This covers the processing fees that are charged to our office.
- All appointments are scheduled and reserved exclusively for you. Please notify us at least 24 hours in advance if you cannot keep your appointment. Canceling an appointment without 24 hours notice can result in a $25.00 cancellation fee.

Insurance Coverage

Your insurance policy is a contract between you and your insurance company. We will assist you with any questions you may have. It is beneficial for you to understand your policy coverage and its limitations. Insurance payment for a claim is never guaranteed. All charges on your account are your responsibility. We will process your insurance claims as long as we have your complete insurance information. In the event that your insurance company has not paid for your treatment(s) in full within 60 days, the balance is then your responsibility.

Fillings

Andrea H. Folatko, D.D.S. Inc. only place resin-based composite fillings, which are environmentally responsible and beneficial to your health. We are happy to discuss the differences between resin-based composite (white) and amalgam (metal) fillings with you. You may be responsible for the difference in price, depending on your insurance.

Frequently Asked Questions (FAQ'S)

How do we determine treatment needed?
Patient standard of care is based on clinical need and not based on what insurance will cover. If you deny recommended treatment, you may be asked to sign a waiver.

Are we in-network for your insurance?
Although we accept most insurance plans, Andrea H. Folatko, D.D.S. Inc. is an "in-network" or "preferred" provider for the following (4) insurance plans:

1. CIGNA TOTAL
2. DELTA (PPO and PREMIER)
2. HUMANA (includes COMPBENEFITS and CENTRAL STATES)
3. METLIFE

What are out-of-network benefits?
If Dr. Folatko is not "in-network" or a "preferred provider" for your insurance, she is considered an "out-of-network" provider. Keep in mind, most insurance companies provide only slightly different coverage for an "out-of-network" dentist, while others will not provide any benefits to an "out-of-network" dentist. You are responsible for any amount not covered by your policy.

How can I find out what my insurance will cover?
We estimate co-insurance payments based on information from your insurance company. Most policies pay based on a percentage calculation of our fees for out-of-network insurance, or their fees for in-network insurance. Pre-estimates can be obtained before treatment upon request.

To determine liability, secure payment or obtain reimbursement, I authorize disclosure of my dental/medical records and release of all information from said insurance company.

I HAVE READ THE ABOVE FINANCIAL POLICY AND AGREE TO COMPLY WITH ALL OF THE TERMS AND CONDITIONS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF PROCEDURES PERFORMED ON ME BY ANDREA H. FOLATKO, D.D.S. INC.

Patient Name (printed) **Patient Signature** **Date**

***Responsible Party (printed)** **Responsible Party Signature** **Date**
****if different than patient***