Hanover Endodontics
201 Allegheny Avenue
Hanover, PA 17331
(717)630-2343

Office Financial Policy

- Payment is due and expected at the time of service. Payment can be made by cash, check, Visa, Discover, Mastercard, or CareCredit.
- I hereby authorize Hanover Endodontics to exchange information to any insurance company or authorized agency specified regarding information concerning my dental treatment.
- **I understand that I am responsible for all deductibles, co-payments, co-insurance, and any non-covered services the day of the visit.**
- Currently Hanover Endodontics participates with United Concordia, Delta Dental, Cigna DPPO/Radius, Metlife, Blue Cross Dental, Carefirst, Aetna, Dentemax, and Connection Dental. Hanover Endodontics does not participate with any Medicare or Medicaid plans. If I have a plan that Hanover Endodontics does not participate with, I will pay the office fees in full at the time of service. Hanover Endodontics will submit to my Out-Of-Network plan on my behalf.
- If for any reason the insurance company sends me the payment for any services provided by Hanover Endodontics and the fees have not already been paid by me in full to their office, I will take full responsibility of making sure the payment is sent to Hanover Endodontics within 15 days of receiving the payment.
- I agree that if there has not been any payments received from my insurance company within 60 days of filing, I have full responsibility of the remaining balance.

Please note that:

- Any checks returned to our office for insufficient funding are subject to an additional fee of $45.00.
- There will be a $75.00 charge for any missed appointments and appointments not rescheduled at least 24 hours in advance.
- Any past due balances not paid in full after 90 days will be sent to a collection agency and a 33% collection fee will be added to my account.
- The price that is quoted to me from Hanover Endodontics is **only an estimate**. If the insurance company overpays, I will be reimbursed. If Hanover Endodontics is underpaid by the insurance company, I will be responsible for the remaining balance.
- If I would like a copy of any of our policies, HIPPA policies, or our fee schedule the front office would be happy to provide one.

Patient Name (Print): ______________________________ Date: __________________

Signature of Patient/Guardian: ____