Office Procedures & Policies

Here at Morris County Dental, we are proud to offer high quality dental care with individualized attention. We are concerned about your dental care and want to ensure that it is performed in the most responsible manner possible. In order to assist you with these goals, we have designed the following procedures and policies. Please feel free to ask us any questions. Thank you.

Insurance, Payment, and Financing

I. Insurance

If you have insurance, we are anxious to help you receive maximum benefits. As a courtesy, we will explore and explain your benefits, and will submit your insurance claims for you. **Please note we do NOT take responsibility for errors in information provided to us by your insurance carrier. Any remaining balances are your responsibility.**

II. Payment

Unless **previous** arrangements have been made, payment is expected at time of service. When multiple visits are necessary for treatment, your payment may be split over the number of visits required. If you have insurance, we will estimate your portion and ask for that amount at time of service. **As stated above, remaining balances become your responsibility**. We accept cash, checks, Visa, Mastercard, Discover, and American Express.

If extensive treatment is necessary, you will most likely have a consultation appointment, which will include financing options. Please see the next section for details.

III. Financing

We offer multiple financing options for extensive treatment. These options include “Pay As You Go,” “Healthcare Financing Options,” and “Automatic Credit Card Payments.” Our “Financing Options” form lists details. Please ask us for one if you are curious and will be inquiring about financing.

IV. Miscellaneous

A. Returned checks are subject to a $30 fee.

B. Interest Charges, Billing Charges, and Failure to Pay Accounts:
Any outstanding balances not paid within 30 days of receiving a statement will be subject to interest (finance) charges at 18% apr applied monthly, or a minimum of $3.00 monthly, whichever is greater. These accounts will also be subject to separate billing charges of $4.00 per month. Failure to make full payment within 90 days will result in the actions of a collection agency or court. You will also be responsible for all reasonable collection costs not to exceed 50% of the balance, court costs, attorney fees and interest fees accrued with the collection of this account.

C. Cancellation & No-Show Policy
We require 48-hour notice if you are unable to keep your appointment. Failure to give us this notice will result in a $15 charge per quarter hour scheduled. We are well aware that emergencies arise, and we are not insensitive to this issue. However, if you do not call us to let us know what is occurring, we reserve the right to impose this fee. We cannot provide our patients with the level of excellence expected of us if we do not have your cooperation with respect to keeping your appointments.

D. Confirmation Policy
We will attempt to text, email, and / or call you anywhere within one week of your appointment to remind you of it. **Please note that these calls are courtesy confirmations: your appointment is still your**

responsibility. We are not responsible for changed phone numbers, full voicemail boxes, email addresses, opting out of automated reminders, or family members that fail to give you messages. If you fail to show for your appointment, you are subject to the fees discussed immediately above.

E. Arbitration

Definitions:

"Patient" is defined to include the individual who actually receives treatment by the practice and, for a minor patient, their parent or guardian who executes this document.

"Practice" is defined to include Morris County Dental Associates, LLC, the legal entity, and all its owners, members, officers, executives, managers, supervisors, employees and independent contractors and contractors.

"Parties" is defined to include Patient and Practice as defined above.

Agreement to Arbitration

All disputes, claims, controversies, complaints, charges, and causes of legal action (hereinafter collectively referenced as "Claims"), which arise out of, are related to, or are connected with, either directly or indirectly or in whole or in part, this Agreement, the business\professional relationship between the Practice and Patient, including, but not limited to, all treatment and care provided by the Practice for the Patient, and the billing and collection for same, and further including all Claims of malpractice or any other allegations of misconduct/wrongdoing by the Practice, shall be adjudicated and finally resolved exclusively through final and binding arbitration before one arbitrator. The arbitrator shall be selected and shall decide the Claim through the procedures for commercial arbitration provided by JAMS, (Judicial Arbitration and Mediation Services) 45 Broadway, New York, New York 10006. The JAMS rules for commercial arbitration can be found at www.jamsadr.com.

This Agreement to arbitration includes having the arbitrator determine the enforceability of this arbitration provision, its applicability to, and the arbitrability of, any particular Claim, whether this provision for arbitration was properly invoked by a Party, and any and all other questions, disputes or issues relating to the use of this arbitration process as the only means to adjudicate and finally resolve any Claim between the Parties.

The Parties acknowledge their understanding that under this provision for arbitration, they are waiving (giving-up) their rights to pursue the adjudication and resolution of any Claim between them through a lawsuit in a court of law with a judge and a trial with a jury.

The arbitration will occur in Morristown, New Jersey, or will be held at any location within the State of New Jersey mutually agreeable to the Parties. The fees and expenses of the arbitrator shall be borne equally by the Parties, unless some other allocation of these expenses is agreed to. Each Party shall pay its own fees and costs relating to the arbitration, including attorney and expert witness fees. Any award rendered by the arbitrator shall be final and binding upon the Parties.

Judgment upon any such arbitration award, and any action to enforce or vacate any arbitration award, will be adjudicated in a New Jersey State Court venued in Morris County, and the laws of the State of New Jersey shall exclusively apply.

The Parties, their attorneys, accountants, tax and investment advisors, experts, expert and lay witnesses, and any and all other individuals who the Parties involve in this arbitration process shall for all time maintain the confidentiality of all aspects of this arbitration process. Each Party shall be responsible for advising all the other individuals, who each Party involves in this arbitration process, of this obligation to maintain this confidentiality.

If for any reason this agreement for arbitration is determined by any court to be unenforceable, and, as a result of such determination, any Claim is adjudicated and resolved in a court of law; then the Parties agree to waive (give-up) their right to have any such Claim tried before a jury, and all such Claims shall be decided by a judge sitting without a jury.

I acknowledge that I have read all the above sections of the Agreement, specifically including the section on Arbitration; that I understand and voluntarily agree to all of them, and that any questions I have asked about them, if any, have all been answered to my satisfaction. I also understand that I am fully responsible for this account, and for any minors listed below.

Name (print)_____ Signature _____ Date _____

IF YOU HAVE DENTAL INSURANCE

In the event that insurance is involved, I assign all insurance benefits be payable to this dental practice. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits from the insurance company. I authorize the use of this signature on all insurance submissions.

_____	_____	_____	_____
Print Name of Responsible Person	Sign Name of Responsible Person	Relationship to Patient	Date

CHILDREN

I hereby give consent for the following minors: (First **AND** Last names, please!!):

Name of Minor	Your relationship to minor		Name of Minor	Your relationship to minor

Updated: 10/7/22