208 DENTAL
Family • Cosmetic • Implants • Dentures

Financial Agreement Policy

Purpose

At 208 Dental, we are committed to providing excellent dental care with transparency in all financial matters. This policy explains your financial responsibility and our office procedures so your care is smooth, predictable, and supported by clear communication.

Payment at Time of Service

Payment for the patient portion of treatment is due on the day services are provided unless a payment plan has been arranged and approved in advance.

"Estimated patient portion" means the amount expected to be due from the patient at the time of scheduling or service, **based on current insurance information, in-office membership plan pricing, or usual and customary (UCR) fees for self-pay patients,** as applicable. This amount is an estimate only and may change based on coverage determinations, plan limitations, treatment provided, or claim processing.

Insurance estimates are **not a guarantee of payment**. The patient is responsible for any balance remaining after insurance or plan benefits are applied.

Accepted Forms of Payment

We accept the following forms of payment:

- Visa
- MasterCard
- American Express
- Discover
- HSA/FSA
- CareCredit
- Wisetack
- Checks
- Cash

CareCredit must be approved and available at the time deposits or balances are due.

Appointment Confirmation Requirement (24 Hours)

To protect clinical time and keep access available for patients who need care, appointments must be confirmed **at least 24 hours prior** to the scheduled appointment time. Appointments may be confirmed by phone, text, or email.

If confirmation is not received, the appointment **may be released** to another patient on our waitlist.

Card on File & Deposits

Card on File Requirement (Scheduling Hold Authorization)

All appointments require a **valid credit or debit card on file** in order to be scheduled. The card is used as a **scheduling hold** to reserve clinical time and is **not charged at the time of booking**, unless a required deposit is collected.

By providing a card on file, the patient authorizes 208 Dental to charge the card **only as permitted under this policy**, including but not limited to:

- Required deposits at the time of scheduling
- Missed appointment or late cancellation fees
- Failed payment obligations related to approved payment plans

Cards are stored securely in compliance with applicable security standards and are not used for services or charges beyond those expressly authorized in this policy.

Deposit Requirement (All Patients)

A **50% deposit of the estimated patient portion** is required **to schedule any appointment** for which a balance is expected, **regardless of whether the estimate is based on insurance benefits, membership plan pricing, or usual and customary (UCR) fees.**

This applies to **all appointments and all estimated amounts due**, including small balances.
The remaining balance is due on the day of service unless a payment plan has been arranged in advance.

48 Business Hours' Definition (For Notice Requirements)

For purposes of cancellations, rescheduling, and deposit forfeiture, **"business hours" exclude weekends and holidays.**

Use of Deposits

- Deposits are applied directly to your treatment balance if you attend your appointment as scheduled.
- If you cancel or reschedule with **at least 48 business hours' notice**, your deposit will be applied to your next scheduled appointment.
- If you miss or cancel an appointment with **less than 48 business hours' notice**, a **$50 missed appointment fee** will be deducted from the deposit.
- Any remaining deposit balance will be refunded or credited to the account, at the office's discretion, **less applicable processing fees**, as outlined below.

Insurance Coverage & Verification

We accept many PPO dental insurance plans but do not participate with all plans. Insurance is a contract between the patient and the insurance company.

As a courtesy, our team verifies benefits and submits claims on the patient's behalf; however:

- Benefits may not be available in time
- Coverage may change without notice
- Claims may process differently than expected

Patients are responsible for understanding their benefits, annual maximums, deductibles, frequency limitations, and whether our office is in-network or out-of-network.

Preventive services may be covered at a higher percentage; however, preventive services still apply toward and reduce the annual maximum, even when covered at 100%.

When patients are referred to a specialist, our office may attempt to estimate remaining benefits; however, this information is not guaranteed. Final coverage determinations are made by the insurance carrier.

If coverage cannot be verified, **payment in full may be required at the time of service.** Any insurance reimbursement will be issued according to plan rules.

The patient remains financially responsible for all charges not paid by insurance.

Prior Dental Treatment & Annual Maximum Limitations

Insurance companies do not always disclose whether a patient has received dental treatment at another office earlier in the benefit year or how much of the annual maximum has already been used. As a result, our office can only estimate remaining benefits based on the information available at the time of verification and the information provided by the patient.

Patients are responsible for informing our office of any recent dental treatment performed elsewhere that may affect available benefits. Treatment estimates are provided in good faith and to the best of our knowledge; however, final coverage determinations and remaining annual maximums are determined by the insurance carrier after claims are processed.

Insurance Claim Filing

Insurance claims are typically submitted within **10–14 business days** of the date of service, provided all required information is available.

Insurance payments received are automatically applied to the patient's account. Any returned, reversed, or recouped insurance payments are automatically reapplied to the patient's responsibility **as determined by the insurance carrier.**

Refunds

Timing

Refunds are processed within **30 business days** after all related insurance claims on the account have been closed.

No-Fee Refunds (Insurance Overpayment Only)

Refunds due solely to insurance overpayment or over-collection based on insurance estimates are **not subject to a processing fee.**

Method of Refund

Refunds are issued to the original form of payment whenever possible, in accordance with payment processor requirements. Requests to issue refunds to a different card are subject to a **5% processing fee.**

5% Processing Fee (When It Applies)

A **5% processing fee** applies to:

- Refund requests unrelated to insurance overpayment
- Requests to transfer payments or refunds to a different card

To avoid this fee, patients may elect to keep the balance as a **credit on the account,** which does not expire and may be applied toward future treatment.

Payment Plans

Payment plans must be arranged and signed **prior to treatment**. A valid credit or debit card must be stored on file for automatic recurring payments.

If a scheduled payment fails, the system may retry the card and we will contact the patient for updated payment information. Any unpaid balance remains the patient's responsibility and may be subject to late fees.

Monthly Late Fee for Unpaid Balances ($25)

If a patient has an unpaid balance and does not maintain a valid payment method on file (including declined cards, failed payment plan charges, refusal to update payment information, or non-response to billing attempts), a **$25 late fee** may be applied **once per month** until the balance is resolved.

Collections

Any unpaid balance is due upon receipt of the statement. Balances not resolved after reasonable billing efforts may be sent to collections. Once in collections, the account must be settled directly with the collection agency.

Non-Covered Services

Some services — **including but not limited to nitrous oxide and cosmetic procedures** — are not typically covered by insurance and must be paid in full at the time of service. Patients will be informed in advance when recommended treatment is expected to be non-covered.

Failed Payments

Returned checks or declined payments may result in a one-time **$25 administrative fee.**