

Lisa A. Muff, DMD
1505 Sullivan Trail
Easton, PA 18040
610-559-8001 * drlisa.com

Insurance Participation and Payment Policy

Insurance

This office currently participates with Aetna PPO, Aetna Discount Plan (AVS), Ameritas, Delta Dental PPO & Premier, Guardian, and United Concordia ELITE PLUS. Some third-party insurance plans may fall under one of our participating plans. At the end of service/treatment, a copay will be collected. The office will then process and submit insurance claims on behalf of the patient. For these insurers only, this office will accept reimbursement for services provided at the rates established by the insurers, subject to the patient's responsibility for deductibles and co-insurance. The office may end insurance participation at any time.

For patients with other insurers than listed above, payment for all services shall be due and payable at the conclusion of the office visit when services are rendered, unless prior financial arrangements have been made. However, as a courtesy, this office will process and submit claims for reimbursement on behalf of the patient, with a request that the insurer remit payment of any portion of the claim that is covered directly to the patient.

Notwithstanding, patients with insurers other than those listed above acknowledge and agree that the patient is responsible for payment in full of all fees for dental services provided, and that any insurance reimbursement for services provided solely between the patient and the insurer.

Method of Payment

This office accepts payment in the form of cash, personal check, Visa, Mastercard, American Express, Discover and CareCredit. In the event that a personal check is returned for insufficient funds, a returned check fee in the amount of \$50.00 shall be added to the patient's bill. A late fee and/or interest may be assessed for any bill or portion thereof outstanding in excess of thirty days.

Cancellation Policy

Patients shall ensure to provide at least forty-eight (48) hours' notice in the event an appointment is required to be canceled and/or rescheduled. A cancellation fee may be charged if sufficient notice is not provided.

I hereby acknowledge receipt of the foregoing policies, the opportunity to discuss any questions with respect thereto with Dr. Muff or her staff, and further acknowledge that payment for all services rendered is subject to the terms and conditions set forth herein.

Patient Signature

Date