

Aspen Dental is committed to providing all patients with exceptional service and care. If you feel you have an issue that cannot be resolved by your Aspen Dental office team, please call our Patient Satisfaction Hotline at 1-866-273-8606 or email us at [patientservices@aspental.com](mailto:patientservices@aspental.com). We will respond to you as quickly as possible, but always within two business days from your initial contact with us. We are committed to your complete satisfaction and we look forward to resolving any patient satisfaction issues quickly and courteously.

### **I. Treatment Plan Estimates**

Aspen Dental prepares a Treatment Plan Estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The Treatment Plan Estimate is a good-faith attempt to predict the cost of your treatment based on the facts known to Aspen Dental when the estimate is made. As your treatment progresses, your dentist may determine in consultation with you that different or additional treatment is necessary and your financial responsibility may change.

If you have dental insurance, it is important to understand that your actual insurance benefits may differ from the benefits estimated in your Treatment Plan Estimate. Your Treatment Plan Estimate of insurance benefits is based on information provided by your insurance company and by you. It is an estimate and your insurance benefits may be higher or lower than estimated. In all cases, you are responsible for amounts not covered by your insurance, unless prohibited by law or contractual agreement.

In all cases, we encourage all patients with insurance to refer to their member handbooks or to call their plan administrators with any questions or concerns relating to specific benefits.

### **II. Predetermination of Insurance Benefits**

If you have insurance benefits, you may have the option to seek a Predetermination of Benefits before you proceed with any treatment.

Predetermination of Benefits is a process whereby your insurance company or plan administrator tells you in advance of treatment what procedures may be covered by your insurance plan, the amount the insurance company may pay toward those procedures, and the amount you may be required to pay. Requesting a Predetermination is like submitting a claim before the dental procedure or service has taken place.

Because the Predetermination comes directly from your insurer or plan administrator, the risk of error as to your coverage is reduced. If your treatment includes extensive or complex services, such as bridges, crowns, dentures or periodontal work, a Predetermination may be particularly helpful to allow you to appropriately budget for the services or discuss any potential alternative treatment that may be available, if necessary.

The Predetermination of Benefits process gives you useful information about what services may be covered. However, your insurer will inform you that a Predetermination of Benefits is not a guarantee of coverage. A Predetermination sets forth your expected benefits based on the information available to the insurer at the time

the Predetermination is prepared. The Predetermination may not consider, for example, a prior claim submitted by another dentist for services provided to you, changes in your coverage that occur after the Predetermination is made but before the services actually are provided, or the insurance company's subsequent opinion that a condition could have been treated by a less costly alternative to the service provided by your dentist.

The time it takes to receive a Predetermination from your insurance company or plan administrator can vary, from as few as two weeks to as many as eight weeks. The decision to seek a Predetermination of Benefits or to proceed with treatment immediately is your own, unless your plan requires otherwise. **Please inform the Office Manager if you would like to request a Predetermination of Benefits from your insurer.**

### **III. Payment Policy**

In all cases, Aspen Dental patients agree to the following payment policies:

- Payment in full of the estimated patient portion of the fees is due no later than when services are rendered.
- For comprehensive treatment plans requiring multiple office visits, Aspen Dental requires a minimum deposit of 60% of the total estimated patient portion of the fees at the start of treatment.
- Patients are always responsible for amounts not covered by insurance, regardless of whether the original estimate included an expected insurance benefit, unless prohibited by law, or unless Aspen Dental has a contractual agreement with my plan prohibiting all or a portion of such charges.
- Patients may, at their discretion, elect to pay in full, in advance for comprehensive treatment plans. Refunds for unused credit balances will be issued pursuant to Aspen Dental's refund policy as stipulated in section IV, below.

### **IV. Refund Policy**

You may discontinue treatment and request a refund from Aspen Dental at any time. Aspen Dental will refund any amount paid for treatment that you did not receive, except when Aspen Dental's policy for Interrupted Services, set forth in section VI, applies.

All Refunds will be processed back to the original form of payment, except cash payments will be refunded by check.

**In all cases, credit balances existing on accounts after 180 days of inactivity will be refunded through the original form of payment, except that cash payments will be refunded by check, and account holders will be sent a letter notifying them of the refund.**

#### **How to Request a Refund**

- ✓ Contact your local office and request a refund
- ✓ Email refund request to: [refundrequest@spendental.com](mailto:refundrequest@spendental.com)
- ✓ Mail refund request to: Aspen Dental Management, Inc.

Attn: Refund Processing  
P.O. Box 3126  
Syracuse, NY 13220

All Refunds will be processed back to the original form of payment, except cash payments will be refunded by check.

### **Cash or Check Payment Refunds**

- **Account Holder Refund Request** – Upon receipt of a request for a refund, Aspen Dental will confirm all payments by check have cleared the bank (may take up to 15 business days). Once the credit balance is confirmed, Aspen Dental will issue a refund check within 10 business days.
- **Account Inactivity Automatic Refund** – If an account is inactive for 21 days with no scheduled appointments, Aspen Dental will inform the account holder in writing that they may request a refund of a credit balance.

### **Major Credit Card Refunds**

Any refund of payment originated through a credit card company must be refunded to the originating credit card account. Please contact your credit card company for more information regarding their refund policy.

- **Account Holder Refund Request** – Aspen Dental will issue credit card refunds within 3 business days. It may take up to 7 business days for the credit card company to post the payment to the cardholder's account.
- **21 Day Automatic Refund of Patient Deposit with No Account Activity / No Scheduled Future Appointment** – Aspen Dental will automatically refund outstanding credit balances to the originating credit card holder's account. A letter is sent by Aspen Dental to the account holder detailing the refund.

### **Third Party Lender Refunds**

Any refund of payment originated through third party lenders must be refunded to the original account. Please contact the third party lender for more information regarding their refund policy as processing of refunds may not be reflected on an account for up to 2 billing cycles.

- **Account Holder Refund Request** – Aspen Dental will issue third party lender refunds within 3 business days.
- **21 Day Automatic Refund of Patient Deposit with No Activity / No Scheduled Future Appointments** – Aspen Dental will automatically refund the outstanding credit balance to the original third party lender account. A letter is sent by Aspen Dental to the account holder detailing the refund.

## **V. Patients with Dental Insurance**

Patients with insurance agree to Aspen Dental's Payment Policy, as stated above, subject to the following:

- A) **In Network:** If Aspen Dental is a participating provider in your plan network, your insurer may

impose requirements on Aspen Dental that affect your financial responsibility for treatment. For example, Aspen Dental may be required to receive approval from you in advance of treatment for non-covered services or may charge you only your co-payment at the time covered services are provided. In all cases, Aspen Dental will bill you pursuant to the terms of its agreement with your insurer.

**B) Out of Network:** Even if Aspen Dental is not a participating or in-network provider with your insurance plan, we will reduce your payment or deposit by your estimated insurance benefit if you assign the benefits to Aspen Dental. If the insurance plan will not pay benefits directly to Aspen Dental, you will bear full financial responsibility for your treatment plan, according to our payment policy.

**C) Insurance Discounts:** Insurance companies often negotiate discounts with Aspen Dental for services provided to their plan members. If your benefit limits are exceeded, Aspen Dental will charge additional services at the discounted rate only if required to do so by your insurer.

## **VI. Treatment Cancellation and Interrupted Services Charges**

Patients requiring crown or bridge services may cancel treatment with no charge prior to natural teeth being prepared or altered for the prosthetic. Once tooth preparation occurs, patients are liable for the estimated full cost of the services even if they choose not to complete treatment.

## **VII. Accepted Forms of Payment**

Aspen Dental accepts cash, personal checks, Visa®, MasterCard®, American Express®, Discover®, assigned insurance benefits and approved third-party financing.

## **VIII. Third-Party Financing**

Aspen Dental offers treatment financing through non-affiliated, third-party lenders (such as CareCredit / GE Money). Aspen Dental pays these companies fees on a sliding scale for making loans available to patients and for the lender's cost of servicing these loans. As the aggregate amount of care financed through these lenders increases, the fees they charge Aspen Dental decrease. This sliding scale pricing arrangement does not affect your loan amount or the cost of your treatment.

Based on the approved credit limit determined by the third party lender the patient may elect to make full or partial payment when treatment is started and is obligated to make payment arrangements for any remaining balance prior to completing treatment.

## **X. Denture Warranty**

A warranty card will be provided with your purchase of full or partial dentures.

ComfiLytes® dentures are eligible for FREE annual professional cleaning and inspection. All of our high-quality ComfiDents® dentures come with a warranty as specified below.

- ComfiLytes®: 7-Year Warranty

- NaturaLytes®: 3-Year Warranty
- Classic: 1-Year Warranty
- Basic: 6-Month Warranty
- FlexiLytes®: 2-Year Warranty
- FlexiLytes® Combo: 2-Year Warranty
- Cast Partial: 6-Month Warranty

However, we will not reconstruct, repair, reline or replace the denture, free of charge, due to any of the following: loss, discoloration, excessive wear (for example, excessive grinding of teeth), inappropriate use (for example, any use not prescribed by the dentist), neglect or abuse. Defects or damages resulting from any adjustment or alterations of your denture by someone other than an authorized Aspen Dental representative are excluded from coverage under our warranty agreement and will render it null and void.

For more information on warranties, please visit <http://www.aspendental.com/dentures.warranty.html>.

**1. Notice of Privacy Practices (must be signed by ALL new patients).**

By signing below, I acknowledge that I have read Aspen Dental's Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature \_\_\_\_\_ Date \_\_\_\_\_

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

**2. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients).**

By signing below, I agree to the terms of the "Aspen Dental Patient Acknowledgements, Agreements, and Authorizations" document.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(If patient is a minor or disabled, the Parent, Guardian or Attorney-in-Fact must sign above and complete the Responsible Party section below)

**3. Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).**

To the extent permitted by law, I consent to Aspen Dental's use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Aspen Dental of the dental benefits otherwise payable to me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If patient is a minor or disabled the Parent, Guardian or Attorney-in-Fact must sign and complete the Responsible Party section below)

**Responsible Party (If patient is under 18 or disabled)**

Circle One: Dr/Mr/Mrs/Ms/Miss

First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Jr/Sr: \_\_\_\_\_

Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone:(\_\_\_\_) \_\_\_\_\_ Cell Phone:(\_\_\_\_) \_\_\_\_\_

Patient SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Patient Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:(circle) **M F**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_