Skylyn Dental Associates

1585 SKYLYN DRIVE | SPARTANBURG, SC 29307 | (864) 573-9255 | FAX (864) 585-8188

OUR FINANCIAL POLICY AND INSURANCE INFORMATION

All patients must complete our Information and Insurance form before seeing the doctor. We accept Cash, Checks or Visa/Master Card. As a courtesy to our patients, we will gladly file your insurance for you. We are equipped to file your claims electronically which accelerates payment of your claim. The total charges for your care is your responsibility whether your insuranace company pays or not. We cannot bill your insurance company unless you give us current insurance information and allow us to copy your insurance card. Your insurance is a contract between you and your insurance company. We are not a party of that contract.

By South Carolina law, your insurance company is required to respond to any claims submitted within 60 days. If your insurance company has not paid any outstanding portion of your bill within 60 days, the balance is expected to be paid in full by you at that time.

Please be aware that some, or perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.

Please be aware that our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. Many insurance companies will advise you that our fees are not usual, or customary. This is an arbitrary determination and may be a stall tactic to avoid reimbursing you for benefits under your insurance policy. Should you feel that you have been treated unfairly by your insurance company, we recommend that you communicate with the South Carolina Insurance Commissioner's Office for assistance at 803-737-6160, or you may write them at S.C. Insurance Commissioner, P.O. Box 100105, Columbia, SC 29202.

Please be aware that some insurance carriers will deny receipt of your claim. We recommend that you follow-up with your insurance carrier within the next 30 days and advise us if there is a problem.

Please be aware that some insurance carriers will request additional information, such as dental records, x-rays, etc., which, in our opinion, unnecessarily delays payment. We respond to each request as quickly as time permits.

We will gladly provide you with a copy of your claim after it has been submitted to your insurance company. However, we will only re-file your claim for you one time without an additional charge to you.

Thank you for choosing us as your dental provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. Non-emergency treatment may be denied for patients who have an outstanding balance unless charges have been pre-authorized to a VISA/MASTERCARD, or payment by cash/check, is made before the treatment/service is performed by us.

We thank you and appreciate your understanding our Financial Policy.

Your signature below will note that you have read and agree to this Financial Policy.

X_____Date: _____

Signature of Patient (or) Responsible Party