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## **BILLING PROCEDURES**

We welcome you to our practice as either a new patient or returning patient and would like to briefly review or update you on our billing procedures.

1. Currently, we participate with only the military Tricare, Medicare, and the local Carefirst and BlueCross Blue Shield Plans. We do not participate with any dental insurance plans.
2. If you do not have one of the above insurance plans, our office will work with you to obtain reimbursement and send claim forms to your insurance company, but you are responsible for all charges.
3. If you have Tricare, we must have received a referral prior to your visit. If you are active duty there is no co-pay. If you are retired there is a \$12.00 co-pay each time you have an office visit. If you have Tricare Standard or Tricare Select, you must pay the deductible plus a 20% co-pay for each procedure.
4. If you have Medicare, to obtain coverage you will have to meet certain Medicare mandated requirements and provide all necessary paperwork prior to your initial visit. You might have to pay a small portion if your secondary insurance does not cover a particular service. Some procedures are not covered under Medicare, and you will need to sign an ABNA form and make payments.
5. Coverage for Carefirst and BlueCross plans varies widely among each group. You must be aware of the rules unique to your group such as co-pays, deductibles, co-insurance and the need to obtain a referral from your primary care provider for visits. We will preauthorize those services that need to be preauthorized. Some procedures may not be covered under your plan or require a co-insurance and you will need to make payment arrangements prior to the start of treatment. Co-payments are due at each office visit.
6. All patients need to understand that if their insurance does not cover a service that they are responsible for any balance. For your convenience we accept VISA, MasterCard, AMEX, Discover, checks, and cash. Payments are due at the time of treatment.

**I have read the above and accept financial responsibility for services rendered.**

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**Patient/Guardian Signature**

**Date**