



Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. All patients must complete our information and insurance form before being seen by the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE WE ACCEPT CASH, CHECKS, VISA / MASTERCARD AND DISCOVER

Regarding Insurance

We may accept assignment of benefits as a service to you. This means we will file a claim with the insurance company for their estimated portion of coverage. However, we must have your insurance information before your scheduled appointment. We are unable to bill your insurance unless you provide us with current insurance information. The balance is your responsibility whether your insurance pays or not.

Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits from your insurance company, we do require that your account is paid in full within 45 days if your insurance has not paid their portion. Your percentage of responsibility is due at time of service. (For example, if the insurance company pays 80% of a covered procedure, the remaining 20% of the balance, plus any deductible, will be due the day of the treatment.)

Please be aware that some, and perhaps all, of the services provided may be non-covered or not considered reasonable and necessary under your dental insurance. You will be given a treatment plan with your ESTIMATED portion due before the treatment is performed.

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due the day of treatment. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

You will be notified if your insurance company has not paid their portion after the 45 day time. If your account goes over 60 days past due, it will be turned over to our collection agency. Any balance over 60 days past due will incur an 18% finance charge.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary-(average) for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Our office files claims with hundreds of insurance companies throughout the United States and each company has their own usual and customary fees for dental procedures.

Adult Patients

There is a \$30 service charge for all returned checks. If a check is returned, you will be notified by letter and telephone. You will be given five (5) business days to bring in your payment which must be by cash or money order. If payment is not received within five business days, your account will be turned over to a collection agency and their fees will be added to your account balance.

Minor Patients

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized with a credit card.

Missed Appointments

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit which is \$35. To help us better serve all of our patients, please do all you can to keep your appointments. As a courtesy our office will try to call all our patients at least one day before their appointment for confirmation.

Collection agency

If your account is not paid in full within 60 days from the date of service, it will be turned over to a collection agency. It is your responsibility to make sure the insurance company pays us in a timely manner because the contract is between you and them. They are paying on your behalf. Should your account balance be turned over to a collection agency, any collection or legal fees that are incurred to collect the amount owed to our office will be charged to your account. Our collection agency charges a 40% fee. For example, if your balance is \$1000, another \$400 would be added to your account for the collection fees.

Please let us know if you have any questions or concerns prior to signing this form.

I have read, understand and agree to this Financial Policy.

Patients Name (please print)

Signature of patient or responsible party

Date

