

# Financial policy

We welcome you to our office

Patient Name \_\_\_\_\_

Our goal is to provide you with the finest care possible and in that regard; we are committed to your treatment being successful. We know that a clearly communicated financial policy assists us in providing the best service for our patients. This should answer some of the most commonly asked questions. We require you to read and sign our financial policy prior to any treatment.

## Please indicate your payment option

Cash or Check

Credit Card

Visa

MasterCard

Discover

Amex

Payment Plan:

- We offer a plan through a local finance company that allows extended payments. There is no application fee or down payment and the loan can be interest free. This loan provides dedicated dental financing that does not affect your credit limit on other credit cards. Please ask for a credit application.
- We also offer payment plans through our office if not accepted by Care Credit. Please ask receptionist for further details.

**Payment, including insurance deductibles and co-payments is expected at each visit.**

## Insurance

- We are happy to extend the courtesy of filling the forms necessary to see that you receive the full benefits of your coverage; however **we cannot and do not guarantee any estimated coverage**. For us to provide this service to you you must fill out the necessary form **correctly** and **completely**, which enables confirmation of your coverage.
- If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you, and you will be expected to pay in full for the services rendered. You are responsible for **notifying our office immediately of any changes** in your insurance carrier or your insurance benefits.
- Your insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Problems with your insurance company with regards to eligibility, allowances, fees and/or coverage, are your responsibility, and will require you contacting them directly.
- Any amount or **balance** not covered by your insurance company for any reason whatsoever is **due in full within 10 days of notification** by our or your insurance company. Any insurance overpayment will be refunded to you by our office within 10 days. If for any reason we have not received payment from your insurance company within 30 days from the start of treatment, you will be billed and are responsible for payment at that time.

## Address & Phone Number Changes

- Please notify our office in a timely manner of any **address / phone number changes**, as it is imperative to have your account updated at all times for a better service and communication.
- It is your **responsibility** to contact our office, if possible in writing, by mail, to make changes to your account, to receive all mail from our office and also to avoid possible account charges / collection due to returned mail or disconnected phone numbers.

## Usual and Customary Fees

- Our practice is committed to providing you with the best treatment.
- Our fees are consistent with what is usual and customary for our area.
- Fees are based on the degree of difficulty, the expertise and time required the cost of any special materials, and the utilization of new technologies.
- Please keep in mind that we can only **estimate** what your insurance company will pay, since each insurance company has their specific limitations and exclusions.
- You are responsible for full payment regardless of any insurance company's arbitrary determination of usual and customary fees.

## Billing

- We assign all accounts that are outstanding over 90 days for collection, regardless of insurance status.
- We apply finance charges of 4.5% to **all** past due accounts, regardless of insurance status.

## Missed Appointments

- If you are unable to keep your scheduled appointment, please call our receptionist during regular hour's office hours at least **48 hours** in advance to reschedule your appointment.
- Failure to provide our receptionist with at least 48 hours notice of cancellation, or failing to keep and appointment, will result in administrative **charge** of 10% of your scheduled appointment.
- Excessive failed appointments will result in a dismissal from the practice.

Should the account become past due, I acknowledge full responsibility and agree to pay any and all costs, including any and all collection agency fees, legal fees, and/or other cost necessary to collect this account.

I have read this agreement, fully understand its content, and agree to this policy.

\_\_\_\_\_  
Responsible Party's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Responsible Party's Name

\_\_\_\_\_  
Date