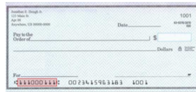
Financial Policy

We welcome you to our office

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
- ☐ Check
- ☐ Visa
- ☐ Mastercard
- ☐ Discover
- ☐ AMEX
- ☐ Care Credit



INSURANCE

- We are happy to extent 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, you must fill out the necessary form correctly and completely, which enables confirmation of your coverage with your designated insurance company.
- 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** with 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 office or your insurance company. Any insurance overpayment will be credited back to your account or you may formally request a refund. 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 AND PHONE NUMBER CHANGES

- Please notify our office in a timely manner of any **address / phone number changes**, as it is imperative that we have your account updated always for a better service and communication.
- It is **your responsibility** to contact our office, if possible in writing, by mail or email to make changes to your account, to receive all mail from our office and 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 material, 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 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 an appointment, **will result in an administration 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 all costs, including all collection agency fees, legal, fees, and / or other costs necessary to collect this account.

I have read this agreement and fully understand it's content and agree to this policy.

Responsible Party's Signature____ Date:______/______/______

Print Responsible Party's Name____