



## Financial Policy

Thank you for choosing our office to serve your dental needs. We are committed to providing you with the highest quality dental care so that you may fully attain optimum oral health. In order to help our patients understand payment for dental services, the following is our policy.

**Payment is due at the time of service.** We accept cash, checks, and major credit cards. If you prefer to make monthly payments, Care Credit is available. Please inquire if interested.

**Patients with Dental Insurance:** We must have pertinent insurance information in order to file a claim. Please advise our staff of any changes in your insurance coverage at check-in. As a courtesy, our office will file your claims. We require you to pay the deductible and your **estimated** portion at the time of service. We must emphasize that this is only an **estimate** and all charges that you incur are your responsibility. Dental insurance companies have a wide variety of rules, plan limitations, and exclusions. Because of this, our office is not responsible for alerting you **prior to treatment** of these stipulations such as waiting periods, maximization of benefits, clauses that deny or lessen payment, etc. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer, and the insurance company. Our office is not a party to that contract. We will cooperate with the requests of your insurance company that may assist in the claim being paid; however, this office will not enter into a dispute with your insurance company over any claim. If your insurance has not paid a claim within 90 days, payment is due at that time.

If you would like to better understand your particular insurance plan's coverage, please contact your carrier and/or request our office to send in a predetermination for proposed procedures as denoted on your treatment plan. This preauthorization will inform you of the portion your primary insurance will cover and your cost per procedure. Our office will provide this to you as a courtesy for treatment over the amount of \$500. Processing may take several weeks, depending on the carrier, so please call our office if you have any questions regarding the results of the preauthorization after that time.

**Past due Accounts:** A finance charge will be imposed on an account which has not been paid within 90 days regardless if insurance has paid. The rate is 1 ½%, per month, annual rate of 18%. We will take necessary steps to collect debt. Your account will be turned over to a collection agency after 120 days. The account holder will be responsible for ALL collection fees the office incurs while attempting to collect the unpaid balance.

**Returned Checks:** There is a \$25.00 fee for any checks returned by the bank.

**Dependent Children and Children of Divorced Parents:** It is the policy of this office to receive payment at the time of service. If an adult other than the parent brings the child to the appointment or the dependent child comes alone, please make prior arrangements for payment to be received the day of treatment. Our office does not separately bill parents. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

**Late Policy:** If you are more than 15 minutes late, we may have to reschedule your appointment depending on our schedule. Please give us a call if you are going to be late so we can assess then whether our schedule can still accommodate you.

**Cancellation Policy:** Your appointment time is reserved specifically for you. Staff time and a room are set aside, and preparations have been made for you. If you need to cancel or reschedule your appointment, we require **24 hours advance notice** in order to avoid a **\$25.00 fee** being charged to your account.

**I have read, understand and agree to the terms and conditions of the "Financial Policy" listed above.**

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_