OFFICE & FINANCIAL POLICIES

Welcome and thank you for choosing our office for your dental care. We are committed to providing you with the highest quality dental care, in an efficient, timely and cost-effective manner. We hope that by providing you with our policies in advance we can prevent any misunderstanding or frustration at the time of your visit.

Initial _____ **Estimated Fees** have been prepared for you is only *an estimate* of what we expect your insurance carrier to pay. Each plan is slightly different in its covered services; it is the insurance carrier's discretion for final payment. If you have any questions on your insurance coverage, please feel free to contact your insurance company or your employer's human resource department.

Initial _____ **Payment.** Payment of fees at the time the service is rendered. There may be a balance due after your claim has been processed and a separate statement will be sent. The policyholder is responsible for all fees not paid by insurance.

Initial _____ ***The patient is responsible for knowing their insurance benefit coverage***. We will gladly file your insurance claim on your behalf. We allow 45 days from the date a claim is filed for the insurance company to pay. If the insurance carrier does NOT pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or "reasonable and customary charges", etc. other than to supply factual information when necessary. You are responsible for the timely payment of your account.

Initial _____ **No Shows and late cancellations** We require a 24-hour advance notice if you must cancel your appointment. If you cancel on the same day as your appointment, you will be considered a NO SHOW for that visit. Each patient is allowed one NO SHOW without penalty. The second NO SHOW may result in a $50 charge to your account. Once you have two NO SHOW appointments in your file, you may also be required to secure any subsequent appointments with a credit card and subsequent NO SHOW appointments may be charged $125.

Initial _____ **Penalties and Fees:**

- A $25 fee will be charged for returned checks.
- Balances of 60 days will be sent to a collection agency. A collection fee of 33% for balances less than 1 year and 50% for balances over 1 year will be added to your account.
- Past-due accounts (over 30 days) will incur interest at a rate of 1.5% monthly.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information necessary for insurance filing and pre-certification by signing this statement.

Patient Name: _____ DOB: _____

Responsible Person's Signature: _____ Date: _____