

OFFICE FINANCIAL POLICY & IMPORTANT INFORMATION REGARDING YOUR DENTAL INSURANCE

We would like our patients to be informed of our office financial policy. We are committed to providing you the best possible care. If you have dental insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

Payment for services is due at the time services are rendered, unless our staff has approved payment arrangements in advance. We accept cash, personal checks, MasterCard and VISA. Returned checks and outstanding balances older than 60 days may be subject to additional collection fees and finance charges at the rate of 1.5% monthly (18% annually). Charges may also be made for broken appointments and appointments canceled without 24 hours advanced notice.

If you have dental insurance you must bring a completed dental claim form or proof of insurance and we will be more than happy to submit your insurance claims for you. However, you must realize:

1. Your insurance is a contract between you and your employer, and the insurance company. We are not a party to that contract.
2. We cannot render services on the assumption the charges will be paid by an insurance company. All charges are your responsibility from the date the services are rendered.
3. Our fees are generally considered to fall within the acceptable range (U.C.R.) by most insurance companies and therefore are covered up to the maximum allowance determined by each carrier.
4. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
5. Remember; please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

We must emphasize that as dental care providers, our relationship is with you, the patient, not your insurance company. Often we do not receive these payments until two to four months after being submitted for payment; therefore, we do ask that you pay your estimated share at the time treatment is rendered. Upon receipt of the insurance payment, we will reconcile your account and bill or refund any difference.

If you have any questions about the above information, please do not hesitate to ask us. We are here to serve you.

I HAVE READ THE POLICIES DESCRIBED IN THIS FORM. I AGREE TO ABIDE BY THE TERMS OUTLINED. I UNDERSTAND AND ACCEPT MY FINANCIAL RESPONSIBILITIES.

Signature of Patient/Responsible Party

Date