

OFFICE POLICY FOR PATIENT FINANCIAL OBLIGATIONS

FIRST VISIT - Patients covered by Dental Insurance need to bring their enrollment card and a copy of their Insurance benefits brochure. If there is a deductible, it should be paid at the time of the first visit. We will do our best in determining what your insurance covers, but remember it is ultimately your responsibility to know what your insurance does and does not cover.

ESTIMATES – Estimates will be given prior to treatment upon request by the patient.

INSURANCE PATIENTS – We welcome dental insurance. Our insurance coordinator is available to facilitate dealing with your insurance company.

- A. As a service to our patients our office will continue to complete and submit all forms to the insurance companies. However, it must be understood that you are ultimately responsible for all fees.
- B. The co-payment or patient's portion of all visits will be due at the time of service.
- C. Any fee not paid by the insurance company within 60 days will be entered as “**no insurance payment received**” on your account and the outstanding balance will then be due and payable by you.

NON INSURANCE PAYMENTS – Payment for services is due on the date of treatment and can be made by cash, personal check, or credit card. Financing options are available upon request. Estimates will be given on request, and financial options may be determined before treatment.

PROSTHETIC TREATMENT – (Crowns, Bridges, Partial Dentures and Full Dentures). Since we are on a cash basis with our laboratories, 50% of the total fee is due at the first prosthetic visit. The balance is due upon completion of the treatment. If a predetermination of benefits has been done with your insurance company and your portion is less than 50% the amount due at the first visit will be reduced.

MISSED APPOINTMENTS – No charge will be made for rescheduling an appointment provided **48 hours notice** is given. Otherwise a **minimum charge of \$40.00** will be incurred. Once an appointment has been made please remember this time has been reserved specifically for you. We try to make confirmation calls to our patients. Please remember ultimately your appointment time is your responsibility.

SERVICE CHARGES – Interest of 1.5% per month (18% per year) will be charged on all accounts more than 60 days old.

LEGAL FEES – The patient agrees to pay legal and collection fees should their account become severely delinquent.

I have read, understand and agree to the above policy for Patients Financial Obligations. I understand that the care and services rendered by the doctor are based on my dental needs and that I am responsible for payment for these services. As a courtesy to me the doctor's office staff will assist in maximizing my dental insurance benefits and will process insurance claims. However, I know I am responsible for any services not paid by my insurance company.

Signature _____ Date _____
Patient (Parent/guardian if patient is a minor)