FINANCIAL PROTOCOLS

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of the Financial Policy that is required you read and sign prior to any treatment.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE. (First New Patient on a New Account and Uninsured Patients)**
- **WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, DEBIT CARDS, AND CARE CREDIT.**
- **WE DO OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL THROUGH CARE CREDIT.**

Regarding Insurance

We may accept assignment of insurance benefits after the second visit. However, we do require deductibles and estimated co-payments to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. ________ Initial

If your insurance company has not paid your account in full within 60 days, you will be required to pay the balance. It is then your responsibility to contact your insurance company about the unpaid claim. If your bill is not paid in full within the next 30 days your account can be turned over to a collection agency and permanently affect your credit record. Please be aware that some, and perhaps all, of the services provided may be non-covered services. ________ Initial

We accept assignment of benefits from only one dental insurance company per patient. It is your responsibility to file claims to your secondary insurance company. This is easily done by requesting a dental claim form from your secondary insurance company, fill out the patient portion, and attach to it the Explanation of Benefits letter that you receive from your primary dental insurance company. ________ Initial

Read and sign here only if you want our office to receive benefits from your insurance company.

I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

X____ Date ____________________

Signature of Patient or Responsible Party

Usual and Customary Rates

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our practice.

Adult Patients

Adult Patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to a credit card, debit card, or Care Credit; or if payment by cash or check at time of service is verified. ________ Initial

Appointment Reservations

Unless canceled at least 2 working days in advance, our policy is to charge for missed appointment reservations at the rate of a normal office visit when this occurs more than twice in a six month period.

Patients who arrive over 15 minutes late for a reserved appointment may be rescheduled so as not to inconvenience other scheduled patients. ________ Initial

Interest

Interest of 1.5% per month is charged on accounts 30 days after treatment or after receipt of insurance payment.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to the Financial Policy:

X____ Date ____________________

Signature of Patient or Responsible Party