

TO OUR VALUED PATIENT:

CHART # _____

Thank you for choosing us as your dental care provider. We are committed to providing you with the best care possible. In order to achieve this goal, we need your assistance and your understanding of our financial policies. If you have any questions or concerns regarding these policies, please feel free to ask any of our staff. If you would like a photocopy of this outline, please ask.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, Discover and American Express. We will submit an insurance claim on your behalf if you show proof of coverage. However, to establish your account, you may need to pay the Deductible first if your insurance company requires it. If you're insurance company changes please notify us immediately.

Please understand the following:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, the patient. If we are a preferred provider, your co-pays/deductibles are due at the time of treatment.

2. Although we routinely try to secure payment from your insurance company by acting as the go-between, all charges are your responsibility whether the insurance company pays or not. You will continue to be responsible for all balances on your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental insurance. Fees for these services, along with the unpaid deductibles and co-payments are due at the time of treatment.

3. You are responsible for knowing your insurance benefits. Is Preauthorization required for any treatment exceeding \$500? Is your insurance a PPO or is it an open plan? If we can be of assistance, please let us know.

4. Please, keep in mind that we will bill your insurance company as a courtesy for any charges that are rendered, but what we estimate for them to pay is just an estimate and whatever is not paid by them is your responsibility to pick up. If your insurance company does not pay in full within 30 days, we ask you contact your insurance company to check status.

5. Any balance due on account over 120 days without payment arrangement will be turned over to the collection agency representing our office to assist in collecting your debt. In the event your account is sent to a collection agency, you will be responsible for any collection fees, legal fees or court costs.

6. Returned checks are subject to a \$25 returned check fee.

7. We reserve the right to charge \$25 per hour for appointments cancelled or broken without 24 hours advance notice.

8. No minor children (under the age of 18 yrs old) will be treated without a parent present at all times.

Our practice is committed to providing the best treatment for our patients. We encourage you to notify us of any changes in your health status or any of the above information.

Signature of Patient

Date