FINANCIAL POLICY

This statement is to inform you of our financial policy. We are committed to providing you with the highest quality dental care using only the best materials and technology available in the market today. Our financial policy is intended to facilitate excellent service while minimizing administrative costs.

All charges incurred are the patient's responsibility regardless of insurance coverage. We must emphasize that as your dental care provider our relationship is with you, not your insurance company. In order for our office to file your insurance claims, you must provide us current dental insurance information at all times.

Our financial policy requires payment or estimated copayment in full at time of service. We accept Cash, Visa, MasterCard, American Express and Discover as methods of payment.

INSURANCE: Dental insurance is a great benefit and helps many people afford dental care. By definition it is an *exclusive contract* between the employee and the insurance carrier. Therefore, all patients are responsible for all dental fees regardless of insurance coverage. We do provide an additional service for our insured patients by submitting their forms directly to their carrier. The amount of coverage that your benefit plan provides is negotiated between your employer and the insurance company. Coverage may be limited by what the insurance company calls the "usual, customary, and reasonable"(UCR) fees. These are ceilings on the fees for dental procedures; set by the insurance company at the benefit plan will stop reimbursement. There may be differences between our fees and the UCR fees because the UCR fees were often determined many years ago, and seldom relevant to quality dentistry in today's market. Any differences between the two fees are the responsibility of you, the patient.

BILLING: There is a $25 charge to accounts for all bank returned checks that have nonsufficient funds. Please be advised there will be interest charges of 1.5% per month (APR 18%) applied to any accounts on delayed payments over 60 days. Accounts overdue will be subject to collection procedures. Any account sent for collections will assess an additional $100 processing fee. **If the account should become delinquent, patient agrees to pay for interest charged, collection costs and attorney fees.** We consider financial matters important and ask you bring any concerns to our attention.

I authorize release of any information relating to this claim. I hereby authorize payment of any insurance benefits/payments due:

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

Signed:_____ Date:_____
Patient, Parent, or Guardian

PATIENT INFORMATION: Please understand your patient information is held in confidences and that no information will be given out without your signed consent. By signing ***this*** form it gives us permission to use your information solely for the purpose of collection of your claim.