

## Patient Financial Policy / Insurance Form

Welcome to our office. We are honored that you have chosen us as your dental healthcare provider. We are committed to providing you with the best possible care! In order to achieve this goal, we need your assistance and understanding of our payment policy listed below.

- Payment is due at the time services are rendered. We accept payment for services in cash, check, and credit card. A discount will be given if payment is in the form of cash or check.
- As a courtesy to our patients, we have extended financing available through Care Credit. \*Subject to credit approval\*
- Treatment plan quotes are effective for 90 days. A treatment plan is an **estimate**. If in the event that clinical conditions warrant a different treatment, a change in fee may occur.
- A \$40.00 NSF fee will be charged for all returned checks.
- Appointments which are failed or cancelled with less than 24 hours advance notice will require a \$50 deposit to reschedule.
- If after multiple attempts are made to collect any outstanding balance, with no response from patient or responsible party, your account may be sent to collections.

### Insurance Information

Name of Ins. Company _____	Policy Holder _____	Relationship to Patient _____
Member ID/ Subscriber # _____	Group # _____	SS# _____
Insurance Co. Address _____	City/State _____	Phone # _____
Employer _____	City/State _____	

We will be happy to file insurance claims on your behalf, and we will work with you to maximize your allowable benefits. Our staff will estimate your co-payment and deductible. This amount is due at the time service is rendered. The amount an insurance company pays, known as usual, customary and reasonable fees, varies greatly. If they pay more than expected, we will either refund you or carry the amount as a credit. If they pay less, we will send you a statement for the balance. We request payment in full in 20 days.

Please note that the contract between you, your employer, and the insurance carrier is designed to assist you with your dental costs. Your charges in our office are your responsibility. We do not base your diagnosed treatment on your insurance coverage. We base it on your needs and desires. We take pride in the quality care we offer our patients and make every effort to have your dental visits with us be as comfortable as possible.

We will make every effort to explain your costs to you and to avoid misunderstandings so that we can focus on your dental health. We value you as a patient and are glad to be of assistance whenever possible.

I have read and understand the above Financial Policy.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_