COMMITTED TO EXCELLENCE IN DENTISTRY AND PERSONAL SERVICE

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AESTHETIC DENTISTRY

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FINANCIAL RESPONSIBILITY

RESPONSIBLE PARTY (if other than the patient):

Name_____ Relationship_____
(First) (MI) (Last)

Street Address_____ City_____ State_____ Zip_____

Telephone: Home_____ Cell_____ Work_____

INSURANCE POLICY

Name Of Insured_____Relationship to patient_____DOB_____/_____/_____
(First) (MI) (Last) (Month/Day/Year)

Social Security# _____Employer _____

Insurance Company_____Policy#_____ Group#_____ID# _____

Thank you for choosing us as your dental care provider. The following information provides the basis for the financial aspect of your treatment. We sincerely desire to treat our patients in a pleasing and congenial atmosphere and find this can best be accomplished when a clear understanding exists regarding financial arrangements. Please contact the office at any time with questions regarding your financial responsibility.

▪PAYMENT: Fees for services are due when treatment is rendered. We accept cash, check or credit card payments.

▪FINANCING: We offer financing through CareCredit for qualifying treatment plans. Many options, including zero interest financing, are available with a $1000 minimum.

▪INSURANCE: If you have dental insurance, we will file the appropriate claim forms with your insurance company, provided you supply us with documented evidence of coverage, ie an insurance card. We will make a good faith estimate of your benefits and defer billing you for that amount for up to 30 days. The patient portion is due when services are rendered. Although we make every effort to help you understand and obtain your benefits, we cannot guarantee your insurance provider will pay. The insurance carrier determines the amount of the reimbursement. We do not accept responsibility for collecting on an insurance claim or for negotiating a settlement on a disputed claim.

▪THIRD PARTY PAYMENT: If the Guarantor of Account is someone other than the patient, financial arrangements must be made prior to treatment being provided.

▪PAST DUE ACCOUNTS: We understand that temporary financial problems may affect the timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account. Any account which is over 90 days past due, without prior arrangements, must be brought current before an appointment will be scheduled. Patients with past due accounts are seen on a pre-pay, emergency basis only.

▪NON-PAYMENT: In the event the charges incurred are not paid in full when due and collection action is instituted, the patient is responsible for the additional costs associated with such collection activity. The collection costs may include and are not limited to collection agency fees, attorney fees, court costs and/or any other expenses incurred in its collection as allowable by law.

▪RETURNED CHECKS: A $25 processing fee will be charged for a returned check.

▪INTEREST: Any account remaining unpaid 30 days from date of service will be charged interest at the rate of 1.5% per month on any unpaid balance (18% per year) unless prior payment arrangements have been approved.

▪CANCELLATION: Patients are expected to notify the office at least 48 hours prior to their scheduled appointment if they cannot keep the appointment. Failure to properly notify the office may result in a charge of $80 per hour of scheduled appointment time. Three non-notified missed appointments may result in dismissal from the practice.

FINANCIAL RESPONSIBILITY AGREEMENT

I have read the financial responsibility for dental services, agree to the terms and accept full responsibility for all charges for services rendered.

Patient or Authorized Representative Signature: _____ Date: _____

Staff Signature: _____ Date: _____