

OFFICE POLICIES

We have established the following office policies. Please place your initials by each to indicate that you have read them.

_____ Payment and/or co-payment is required in full at the time services are provided.

_____ A \$10 infection control fee is charged for each visit. This fee covers the disposable items and the sterilization and disinfectant technology involved in your visits as required by law (OSHA). More information about this is available at the front desk.

_____ At least 48 hours advance notice is required for all appointment changes or cancellations. Otherwise, a \$25 fee is charged for each appointment so affected; an additional \$25 cancellation fee is charged for appointments with specialists.

_____ If you have any questions about your insurance, please let us answer them before treatment begins. Otherwise, the assumption will be made that you are familiar with your dental plan coverage and limitations. Please note that dental insurance is very different than medical insurance and that in most cases a co-payment is required.

_____ Please be advised that the co-payment requested for services rendered is only an estimate of what the insurance will not cover, as determined from the information provided by the insurance company. The information given to our office is not a guarantee of payment, and the actual insurance benefit may differ from our estimates. The account holder is responsible for whatever the insurance company does not pay within 45 days.

_____ Valid identification is required for all personal checks. A \$35 fee is charged for each returned check. Accounts not reconciled within 10 days of a check return will be charged an additional \$50 fee for legal pursuit of the issue.

_____ Past due accounts (having a balance due for more than 60 days) will be charged 1.5% interest per month until account is reconciled. Delinquent accounts (having a balance due for more than 90 days) will be transferred to a collection agency. Any and all charges incurred in the pursuit of the debt by that agency or any other third party will be the full responsibility of the account holder.

I, the undersigned, certify that I have read, understand, and agree to abide by the above policies.

Responsible Party Signature

Date

FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy so that we minimize our billing cost. **ALL PATIENTS MUST COMPLETE OUR OFFICE HEALTH HISTORY AND FINANCIAL POLICY IN ITS ENTIRETY PRIOR TO BEING SEEN BY THE DOCTOR.** Payment is expected at time of service, unless other arrangements have been made, prior to the treatment.

INSURANCE:

The patient (or responsible party) is responsible to pay any deductible and percentage **AT THE TIME OF SERVICE.** If payment is not made on the treatment date, the office will not honor the insurance benefit, and the patient will be responsible to pay usual and customary fees. The percentage quoted to you is **an estimate** and not a guarantee of payment from your insurance company. In order for us to file claims on your behalf, you must supply us with all the necessary insurance information. Please refer to your insurance manual for specific coverage. Your insurance policy is a contract between you and your insurance company and we file your claim as a courtesy. If your account has not been paid within 45 days, **the balance will be due in full by you, regardless of insurance status.**

For the plans which we are a participating provider, we will submit the claim for you. The plans which we are not a participating provider, we will submit the claim to your insurance carrier. If an overpayment occurs, we will refund the payment to you at our earliest convenience.

MINOR PATIENTS:

Unaccompanied minors will not be seen without written permission from a parent or guardian. The parent, guardian or adult accompanying a minor is responsible for full payment, their deductible or percentage, **AT THE TIME OF SERVICE.** For unaccompanied minors, non-emergency treatment will be denied unless charges have been prepaid or the minor comes prepared **AT THE TIME OF SERVICE.**

FINANCE CHARGES

Any account balance carried over 45 days will be subject to 1.5% interest fee per month. In the event the account is turned over to a collection agency, the patient or responsible party shall be liable for any clerical, legal and collection fees incurred, up to 30% of the outstanding balance. Also, please note, balances sent to our collection agency will be billed to our usual customary fees, which will forfeit your insurance benefits.

I UNDERSTAND AND AGREE TO THIS POLICY

SIGNATURE OF PATIENT/GUARDIAN

DATE