FAMILY DENTAL CLINIC FINANCIAL POLICY

- **INSURANCE: YOUR DEDUCTIBLE AND ESTIMATED OUT OF POCKET EXPENSES ARE DUE THE DAY OF TREATMENT.**
- We will provide you with a benefit breakdown and estimate of your portion of the treatment needed, based on the information we receive from your insurance company. *We will make every effort to come as close as possible to your actual out of pocket expense.*
- The estimate we supply is not a guarantee of payment. You are responsible for all treatment fees incurred.
- Dental insurance is a contract between you and your insurance company. It is the patient's responsibility to have a clear understanding of the insurance benefits. Please contact your insurance company for details.
- As a courtesy to our patients, we will submit the insurance claims, provided we are supplied with current insurance information as well as a copy of your insurance card.
- If the insurance company pays benefits directly to you, payment will be due in full at the time of service.
- All payments by insurance companies, including usual and customary, reasonable and allowed fees, are governed by the insurance company. They have nothing to do with the actual fee for the services rendered. Our fees are based upon a combination of our costs, time, and our dedication to provide our patients with the highest standard of dental care possible. The difference between the price of the procedure and what the insurance company pays will be the responsibility of the patient.

OUTSTANDING BALANCES:

- Statements will be mailed once insurance pays their portion.
- There will be a 1.5% per month finance charge applied to all accounts with a balance due after 60 days.
- We have the right to begin the collection process if your account is 90 days past due and no financial arrangements have been made. If a collection agency becomes involved, you will be responsible for any collection costs incurred in addition to the outstanding balance.

PATIENTS WITHOUT INSURANCE: Payment Options:

- 100% of payment is due at the time of service.
  Cash – 5% discount when total is paid in full at time of service
  Credit Card – to include Visa, Master Card & Discover
  Care Credit – Medical credit card.

CONSENT: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that payment for dental services provided in this office for myself or my dependents is my responsibility, due and payable at the time services are rendered.

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Signature of Patient, Guardian or Responsible Party Date

Print Name of Patient: _____