Financial Policy Acknowledgment

I am committed to providing you and your family with the best possible dental care. My primary responsibility is to help my patients experience good overall health, and I wish to spend my time and energy toward that end. In the interest of good oral healthcare practice, it is my desire to establish a credit policy to avoid misunderstanding. My fees reflect my professional commitment to excellence. If you have dental insurance I will gladly help you receive your maximum allowable benefits.

Noninsured patients are expected to pay fees in full at the time of service unless prior arrangements have been made. For your convenience I accept cash, checks, VISA, MasterCard, and American Express. Information regarding extended payment plans through CareCredit is also available.

For insured patients, I will gladly accept payment directly from your insurance company only for that percentage the company will cover and do require that the deductible and noncovered fees be paid at each visit. Even though you may have an insurance claim pending, you will receive a monthly statement for the outstanding balance on your account.

Your insurance benefit is a contract between you, your employer, and your insurance company. I am not a party to that contract. It is your responsibility to know the terms and benefits of your insurance contract. This office will file primary insurance as a courtesy to you. Due to the time and expenses involved, there will be a $10.00 administrative fee for billing all secondary insurances.

My fees generally, but not necessarily, fall within the UCR (usual, customary, and reasonable) fee structure determined by your insurance carrier. Not all services are a covered benefit in all contracts. Treatment may exceed your annual benefit maximum. Upon request, a predetermined estimate of benefits will be given to you. You (not the insurance company) are responsible to Prestige Family Dentistry for all fees for services rendered to you.

Returned checks (NSF) will be subject to a $35.00 administrative fee. There will be a flat fee of $50.00 for any appointment, Monday through Friday, not canceled within 24 hours before the scheduled appointment. This office will not reschedule any patient after two consecutively missed appointments. My time must be used as efficiently and effectively as possible to keep expenses at a minimum and fees within reasonable limits.

I will gladly discuss your proposed treatment and answer any questions you might have as to the involvement of your benefit program in receiving this care. This office appreciates the opportunity to serve you.

THERE IS NO INTEREST OR FINANCE CHARGE ON CURRENT ACCOUNTS. AFTER 90 DAYS, ALL ACCOUNTS ARE SUBJECT TO A FINANCE CHARGE OF 1.75% PER MONTH, WHICH IS AN ANNUAL PERCENTAGE RATE OF 21% (or a minimum charge of $1.00).

I, ____, have read this financial policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to a credit-reporting collection service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all legal costs and expenses, including reasonable attorney fees.

Name: ____

Parent/Guardian: ____ Date: ____________________

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