Financial Policy

My signature below shall serve as my authorization to assign any dental benefits paid by any third-party insurer to my provider. If I have insurance I agree to make a payment of my estimated co-payment at the time services are rendered.

I understand that estimated co-payments are estimates only, subject to policy maximums, limitations, coordination of benefit rules and information received from me. After 60 days from the date of treatment any unpaid portion of my bill for services rendered shall be my sole and exclusive responsibility.

Patients understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all balances.

As a courtesy, this office will prepare insurance forms and assist in making collections from insurance companies; however, payment is ultimately the patient's sole and exclusive responsibility should the insurer or third-party payer fail, refuse or otherwise neglect to make payment. All collections from third-parties or insurers will be credited to the patient's account.

If I do not have insurance, all fees for services rendered are due on the date of service unless prior arrangements have been made in advance.

Treatment plan estimate is an estimate of the potential costs that can be incurred during treatment. This is a dynamic number that can change if the treatment itself changes during delivery. Unforeseen clinical issues, esthetic concerns, or functional considerations may come up that will limit our original treatment plan and we may need to alter it.

All changes will be discussed with the patients upfront and financial repercussions addressed as needed.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_