**Patient Financial Policy**

Patient Name:

Patient ID#:

Thank you for choosing \_\_\_\_\_ (Practice Name) as your dental health care specialist. Our main concern is that you receive the proper and optimal treatment needed to improve and maintain your oral health. To avoid any possible misunderstandings regarding payments for services rendered, we are providing you with this statement of our financial policy. If you have any questions or concerns about our payment policies, please do not hesitate to ask our office staff.

1. For your convenience, our office accepts cash, personal checks, and three major credit cards for services. As a courtesy, we are happy to verify your benefits and bill your insurance. Please ask us in advance if you would like us to take care of this for you.
2. Insurance verification is not a guarantee of benefits or payment from the insurance company. We use the information we receive to estimate your insurance coverage as closely as possible. Because of this, we ask for you to pay your deductible as well as the *estimated* portion of your charges the day services are rendered. If the insurance company has not fully paid a claim after a reasonable period of time (usually 30 days), you will be required to pay the remaining portion.
3. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. We are happy to provide as much information for you as possible, but ultimately it is your responsibility to understand your insurance policy. \_\_\_\_\_\_\_\_\_ (Initial)
4. If your insurance coverage pays on a different fee schedule than our fee, you will be responsible for paying the difference. Please understand that we file and accept assignment of your insurance benefits as a courtesy to you*.* If your insurance denies coverage or does not pay *for any reason*, you are ultimately responsible for any and all charges incurred in our office**.**
5. Account balances older than 60 days will be subject to finance charges of 1.5% per month, 19% per year, which will be added to your account. Balances older than 90 days will be subject to collection proceedings. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.
6. We are happy to accept checks from our patients. If you do not have insurance coverage, we offer a 5% discount for checks written on the day of services to our office. Retuned checks will be subject to additional collection fees of $40.00.

Thank you for trusting us with your dental care. Any questions may be directed to our Office Manager, who can be reached at \_\_\_\_\_ (Practice Number) during our regular business hours.

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| --- | --- | --- |
| **Procedure** | **Unit(s)** | **Cost** |
| D7210 Surgical Extraction  Teeth Numbers: |  | $ |
| D9222 First 15 Min of General Anesthesia |  | $ |
| D9223 General Anesthesia  Number of Units |  | $ |
| **Total Cost** |  | **$** |

**Total amount patient is responsible for:** $ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Estimated %** of insurance contribution: % \_\_\_\_\_\_\_\_\_\_\_\_

Payment requested at time of service: $ \_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGEMENT OF NOTICE OF FINANCIAL POLICY**

***My signature certifies that I have read and understand the Financial Policy.***

***I agree to abide by it and will provide payment with one of the following****:*

Cash  Check  MasterCard  VISA  CareCredit

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (patient / guardian) Date