Acknowledgement of Financial Policy

All patients and/or responsible parties agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization the patient and/or responsible party agree to pay applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible parties also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payers.

PATIENTS WITHOUT DENTAL INSURANCE

Payment due at the time services is rendered. On more extensive cases (i.e. crown and bridge, partial dentures, etc.) we would expect 1/3 down, 1/3 in 30 days and the remaining 1/3 in 60 days.

PATIENTS WITH DENTAL INSURANCE

Deductible and estimated co-payment due at the time services is rendered. On more extensive cases we will need to find out the maximum remaining on your dental benefits as this will be deducted from your payment plan. We would expect 1/3 down, 1/3 in 30 days and the remaining 1/3 in 60 days.

FOR ALL PATIENTS

Our financial policy requires arrangements for payment to be made prior to appointment. If a payment is made after the due date there will be a $20.00 late fee applied. Your payment plan is interest free for the 1st 89 days. Accounts that are 90 days and over will assess finance charge of 1% each month, 12% annual.

Accounts that are 90 days overdue will result in not being able to receive additional services except for emergencies or when there is prepayment for additional services.

In the case of default on payment of this account, I agree to pay collection cost and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We offer a 5% senior citizen discount for our patients who are 62 or older.

Occasionally, unforeseen situations do arise which prevent a patient from making their appointment. If unable to keep an appointment, please give 48 hours notice. Otherwise we reserve the right to charge $50.00 for a broken appointment fee.

X_____ X_____

Signature of patient/responsible party Date

ADA FAMILY
DENTISTRY

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