



## **Financial Policy and Explanation of Possible Fees**

### **INSURANCE POLICY**

Our office has prepared a letter regarding insurance policy in this office. Please read it and take a copy home for your records. Your signature below indicates you have read and received this letter. A copy will be placed in your dental record.

### **SIGNATURE ON FILE:**

It is important to have a signature on file for any insurance submissions so your insurance will process and pay their portion for services billed to you. You will be given this form to read and sign once a plan of treatment has been presented.

### **BROKEN APPOINTMENT FEE:**

While we understand that unforeseen circumstances may interfere with appointments, please be aware that this office reserves your appointment time especially for you; therefore, A FEE OF \$1.00 FOR EACH MINUTE OF SCHEDULED TIME, will be assessed for cancellations of less than 48 hours, no exceptions.

### **FINANCIAL ARRANGEMENTS**

Payment for all treatments less than \$250 is expected at the time of service including co-payments. A receipt or statement can be issued for reimbursement accounts. For amounts over \$250, financial arrangements are available. A review of the available payment options will be presented and you will be given the opportunity to ask any questions about the aforementioned payment options. A signed financial arrangements agreements document will be completed prior to any treatment being started.

### **PROMPT PAYMENT**

Accounts are considered to be in good standing for thirty days after the billing date. Accounts that are 31-60 days past the billing date are considered past due. Accounts unpaid after 60 days are seriously past due and eligible for a pre-collection action. After this process, the account will be turned over to a collection agency. Please keep your accounts current to avoid any late charges or unnecessary actions or additional fees as indicated below.

### **LATE CHARGES**

If I do not pay the entire new balance within 30 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current will result in being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs, court costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

### **RECORDS REQUEST**

As a courtesy to other dental practitioners we are happy to send to or receive from them copies of your dental records including xrays at no cost. If, however, you choose to pick up or hand carry the records from our office, there is a \$35.00 fee to cover duplication and processing costs. There are no exceptions. All records releases require the completion of a release authorization form; no records will be released to you or any other doctor if we do not have this form completed IN ADVANCE- no exceptions.

**I have read all of the above policies and understand them.**

**X** \_\_\_\_\_ **DATE** \_\_\_\_\_  
Signature of Patient or Parent (if minor)