CONWAY VILLAGE DENTAL

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FINANCIAL POLICY

This form explains to all of our patients the billing process specific to our office -- much like a payment agreement for a credit card, or billing policies and procedures for utility companies. For the answers to any questions you have, please refer to our front desk staff-- they are here to help!

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Since our practice is also a business with obligations that must be met, we ask that all patient that do not have dental insurance pay for their treatment in full on the day of each visit to our office unless prior arrangements have been made.

We will do our best to give you a rough estimate of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close estimate of your next visit's total bill. Please bring cash, check or credit card at the time of treatment. With a proper diagnosis and a timely treatment plan, most estimates we provide are accurate.

Outstanding balances on your account are discouraged, and must be cleared before the next appointment for any account member or within 30 days of treatment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amount due and not paid in full within 60 days will be charged interest at a rate of 1.8% per month.

A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear must be paid in cash, or by VISA, MasterCard, or Discover.

Your dental appointments are scheduled carefully. Time, trained personnel and dental equipment are reserved for each procedure. Missed appointments add to the cost of dental care when reserved facilities are left waiting empty. We request 24 hour advance notice for rescheduling your appointment. Your account will be charged a broken appointment fee of $50.00 for any missed appointments without proper notification. We reserve the right to terminate professional treatment of any patient if multiple scheduled appointments are not kept.

Minor Patients. The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without exception. This office will not attempt to collect from a parent that is not present in the office at the visit.

You need to bring your insurance card, coverage booklet, and a completed and signed dental insurance claim form at your first visit, and at any time your insurance changes. You need to be aware that:

• We will always do our best to help you to maximize your benefits.

• Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract.

• Your treatment plan is individually tailored and based on your unique oral health needs. It is not based on your dental insurance benefits or lack of benefits.

• Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or your employer.

• As a courtesy to all of our insured patients, we will file your dental insurance claim immediately, and benefits are expected to be paid within 30 days. The filing of an insurance claim does not relieve you of timely payment on your account. You are responsible at the time of treatment for payment to us of any applicable deductible and for your coinsurance portion. You are responsible for any amounts your insurance company chooses not to pay, for whatever reason. Any amounts expected to be paid by your insurance company, but not cleared by them within 60 days become your responsibility and, if not paid in a timely fashion, will begin to accumulate interest at the rate of 1.8% per month. *Please feel free to contact your insurance company regarding unpaid benefits.*

I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described so as to avoid any additional fees. I hereby authorize my insurance benefits to be paid directly to Conway Village Dental I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

PRINT PATIENT NAME_____

SIGNATURE (PARENT/GUARDIAN IF DEPENDENT) _____

DATE_____