Cosmetic & Family Dentistry

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FINANCIAL POLICY/ASSIGNMENT OF BENEFITS

Financial arrangement/responsibility must be made in advance of any treatment performed on any patient. The practice depends upon reimbursement from patients for the costs incurred in their care.

All emergency dental services & any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

I understand that the fee estimates for dental care can only be extended for a period of 6 months from the date of consultation. Fees are subject to increase or change after this time period. Cosmetic Procedures not covered by insurance are 100% the patient's responsibility.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

Patients who carry dental insurance understand that all dental services are charged directly to the patient & that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. However, this dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

Treatment Plan estimates serve ONLY as a PATIENT COST ESTIMATE of the procedures based on information we have received from you & your insurance provider, as you are responsible for all charges regardless of insurance coverage.

I grant my permission to you or your assignee, to telephone me to discuss matters related to this form.

Although we are willing to electronically file insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations & requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

☐ ***I have read the above conditions of treatment and payment and agree to their content.**

Signature of guarantor of payment/responsible party:

Signature _____ **Date** _____

Response Date: ____/____/_____