SpringRockDental

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

**FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS CREDIT CARDS, AND DEBIT CARDS.**

**INSURANCE POLICY**

We request that any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time the service is provided. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance unless you bring in all insurance information at your initial visit. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to your account. Please be aware some and possibly all of the services provided may be non-covered services and not considered reasonable, usual, and customary under the terms of your dental and/or medical policy.

**USUAL AND CUSTOMARY RATES**

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

**ADULT PATIENTS**

Adult patients are responsible for full payment at the time of service. If you are unable to pay at this time, be sure to point this out when you arrive for you appointment.

**MINOR PATIENTS**

The adult accompanying a minor and/or the parents (or guardians) are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, or payment by cash or check at time of service has been verified.

**MISSED APPOINTMENTS**

**Unless cancelled at least 24 hours in advance, our policy is to charge $30 for missed appointments.** Please understand that missed appointment times are valuable to those patients that may find it hard to come to the dentist at other times. Please help us serve you better by keeping your scheduled appointments. Excessive cancellations and no shows will result in termination of our treatment agreement and your records can be forwarded to another dental office for a $10 fee.

**COLLECTIONS**

Any account that has not received payment in 60 days will be handed over to a collection agency that will pursue the responsible party for reimbursement. This will negatively impact your credit history and limit the treatment you can receive at our office. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the

responsibility of the adult person(s) named on the account. Monthly service fee of 1.5% per month or 18% per annum will be assessed on all past due accounts. In the event our office is not contacted within 30 days of you receiving our last billing statement your account will be turned over to our collection agency. There is also a $30 returned check fee.

**REFUNDS**

Refunds for overpayment will be sent after all treatment is completed and insurance has been collected.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. We look forward to providing the highest quality dental care in a relaxing and caring atmosphere. I have thoroughly read the Financial Policy. I understand and agree to this Financial Policy. This copy is for your records, please sign the acknowledgement form.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to any for all costs and expenses, including reasonable attorney fees. I hereby authorize SpringRock Dental to release information necessary to secure payment.


_____ _____

Signature Date

_____

Printed Name