PARK FAMILY DENTAL

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Financial policy

Thank you for choosing us as your dental care provider. Our goal is that you receive the optimal treatments needed to restore your health. The primary focus of our dental practice is to provide the highest quality dental care in the most gentle, efficient and enthusiastic manner. However, we ask for all patients pay for their treatment in full on the date of each visit to our office unless prior arrangements have been made. The following is our financial policy.

Dental Insurance:

If you have dental insurance the office will work with you to maximize your allowable insurance benefits and will assist you in making necessary filings with your insurance company. It is understood that the practice will diagnose treatment based on your dental health and not your insurance coverage. It is further understood that, since your insurance is a contract between you and your insurance company/employer, the practice cannot assume responsibility for coverage or other determinations made by your insurance company and that you will be responsible for timely payment received from the practice regardless of your insurance status.

Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage. We will send a monthly statement. Most insurance companies respond within 3-4 weeks. Please call your insurance company if your statement does not reflect payment within this time frame. Any remaining balance after your insurance company has responded is your responsibility. Your prompt payment is appreciated.
If payment is not received within 60 days, the balance becomes your responsibility. You, the patient, will have to contact your insurance company to determine why payment has not been made.

Your complete dental insurance information must be presented at the time services are provided. It is your responsibility to make sure we have accurate insurance carrier information and billing information. Diagnosis and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance.

Past Due Balances:

Account balances over 60 days will be charged interest rate of 1.5% per month or 18% annually.

Medical Insurance and 3rd Party Insurances: **Medical insurance and auto insurance will be billed as a courtesy to you. If no payment is received within 30 days the balance is your responsibility and is due.** **Dental Care Financing:**
We have arranged special financing with certain outside financing company to reduce the financial barriers for our patients in receiving optimal care. We do not carry account balances in our office.

Estimates:

Fees quoted for treatment will remain in affect for 90 days, and treatment thereafter are subject to change without notice. In the event clinical conditions warrant a modification in treatment, you will be notified of modifications in treatment and the associated fees prior to proceeding with the modified treatment. With proper diagnosis and a timely treatment plan, most estimates we provide are accurate. It is also our office policy that when a root canal therapy, crown, bridge or any other procedure he/she is to return to our office to finalize the treatment.

Returned Checks:

A fee of $35.00 will be charged for any returned checks on your account and full payment along with fee must be paid by cash, VISA, MasterCard, or Discover within 10 days.

Missed appointments:

Unless cancelled within 24 hours in advance, our policy is to charge for the third missed appointment at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Many times a simple phone call will clear any misunderstanding. Our office staff is always willing and available to discuss billing matters with you at any time; we know that you will agree that your clear understanding of your financial policy is important to our professional relationship.
In the event of default, I agree to pay legal interest on the debt, together with such collection cost and reasonable attorney fees as may be required for collection of this note.

Assignment of Benefits:

I hereby guarantee all charges incurred by this office. I hereby assign and direct to pay any and all benefits for dental services under this claim directly to the provider. I hereby authorize the release of any medical information requested by the insurance companies with the above assignment.

Patients Printed Name: ____

Patients Signature: _________________________________ Date____________________