OFFICE POLICIES AND FINANCIAL AGREEMENT

To Our Valued Patient:

Thank you for choosing Dr. B. Dentistry to service your dental needs and concerns. The following describes our office policies and financial agreement. We ask that you please read, agree to, and sign this document so that we have your permission to provide the highest standards in quality dental care.

_______ **PAYMENT OPTIONS**

Our office accepts payment in the form of cash, check, Visa, Mastercard, American Express, Discovery, Pay Pal, or Care Credit. For payments made in full on the day of service, we offer a 5% discount when paying by cash or check. If you are interested in a zero-interest monthly payment plan, please contact any member of our administrative team to assist you in completing an application form for Care Credit, our financial partner. A fee of $25 will be charged on all returned checks as well as a reversal of any pre-pay discount. For those patients who have a history of less than five payments to the company, they will be expected to pay by only cash or credit/debit card for a period of three months before checks will be considered an acceptable form of payment once more.

_______ **INSURANCE CONSIDERATIONS**

For patients paying with insurance, be prepared to show the insurance card and photo identification at the time of treatment. It is the patient's/guarantor's responsibility to provide any new information regarding insurance. Please know that we take pride in giving our patients honest, sincere recommendations based on their personal dental care needs, and not based on their insurance coverage. We submit insurance claims to insurance companies and strive to maximize insurance benefits as a courtesy to our patients. However, due to pending claims, privacy issues, and changes made by employers, we do not always know how much an insurance company has already paid or will pay. It is also important to understand that an insurance contract is between the insured and the insurance company, and that dental insurance was never designed to pay for all dental care. Therefore, at the time of treatment the patient/guarantor is responsible for the estimated portion of payment that their insurance company does not cover. In addition, the patient/guarantor authorizes Dr. B. Dentistry to accept direct payment from the insurance company upon receipt on behalf of the patient. If, for some unforeseen reason, your insurance carrier has denied or not made payment within 60 days, the patient/guarantor is responsible for the balance in full. It is the patient's responsibility to notify our administration office of the order in which to process claims. If the patient does not disclose this order to us, we will use our professional judgment to decide for the patient.

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_______ **ACCOUNTS WITH CREDIT BALANCES AND DELINQUENT ACCOUNTS**

For any account that has a credit balance from duplicate payments, the patient can request a refund and expect a monetary refund check to be mailed to the most recent address on file within thirty days of the request. If the patient does not request a refund, any account that has a credit balance over $1.00 after 90 days will receive a monetary refund check by mail dependent upon the most recent address on file unless the patient requests a credit balance be retained. To keep the responsible party informed of account activity, any account with monies due will receive a courtesy statement each month even if insurance payment is pending. After 60 days, a monthly finance charge of 1.5% will be applied to any account not paid in full. Any account not paid in full after 90 days will be charged an additional 40% of the outstanding balance and submitted to a collection agency.

_______ **CANCELLATION POLICY**

If you are unable to keep an appointment, we kindly ask that you provide us with a minimum of two-business days notice. Our office does not accept cancellations or changes in appointments after-hours by voice-mail, so you must call during normal business hours. This courtesy allows another fellow-patient to utilize that appointment time for their needs and ultimately contributes to reducing the rising costs of health care. Any patient in active treatment who fails to comply with this policy three times in 18 months will be expected to pay a deposit to reserve their next appointment. The deposit amount will be 25% of the scheduled services (regardless of insurance coverage). Once the services are performed, the deposit will be credited towards the bill. Any leftover credit (in the case of insurance reimbursement) will be used towards the next appointment reservation or refunded if the patient so desires. If the patient again fails to comply with the policy, then the patient loses the deposit for that appointment and must place another deposit in order to reserve a second appointment. By adhering to this policy, our office can ensure greater appointment availability to our patients, thereby allowing us to take even better care of you when you need us most.

_______ **OFFICE HOURS**

Monday 8:00 am – 5:00 pm
Tuesday 8:00 am – 5:00 pm
Wednesday 8:00 am – 4: 00 pm
Thursday 8:00 am – 5:00 pm
Friday 8:00 am – Noon

I have read, understand and agree to the above Office Policies and Financial Agreement. I also understand that this agreement is subject to change, and that I can request a copy of the most recent version at any time.

Signature of Patient/Guarantor/Parent/Guardian Date

Name of Child (if applicable)

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