



Understanding Your Financial Responsibility

We would like to welcome you to our practice! We ask that you please take a few minutes to read and sign this. We do this to help prevent any misunderstanding regarding our offices' financial policy. In general, we submit all claims to your insurance company while not participating with any insurance. If you do not have dental insurance we ask that you pay the fee at the time of service unless other arrangements are made.

We have found in the past that many times patients do not understand the role dental insurance plays in their treatment. We will gladly try to answer any questions related to your insurance, but insurance plans vary considerably and we cannot predict or guarantee what part of the service will or will not be covered. Most dental insurance does not cover all the expenses related to your dental treatment. Most, BUT NOT ALL, plans cover 80% of basic work, such as fillings, and 50% major services (crowns, bridges, partials). Some plans do not cover major services at all; it is the patient's responsibility to know their coverage. **You must realize, however, that your insurance is a contract between you, your employer (possibly), and the insurance company.** We will bill your insurance company, as a courtesy.

It is impossible for us to know with certainty what your insurance will or will not cover. We will be happy to assist you with a pre-determination of major services (such as crowns) when needed. We will not be able to know at any given time if your insurance covers the work you need. **We strongly advise you to make yourself aware of the provisions of your dental insurance.** Therefore, if you have treatment in our office, you will be responsible for payment of the balance in full whether your insurance covers it or not.

If we enter into a financial agreement with you involving payment over time and you fail to honor that agreement, we reserve the right to institute collection proceedings using a timetable we determine. This will likely be within 90 days of your breach of the agreement. You will be responsible for all collection-related fees, which may run 25% of your total balance due. Should this happen, we reserve the right to refuse additional non-emergency treatment to you, your spouse and any dependent children until the balance and all fees have been satisfied.

We accept cash, checks, VISA, MasterCard, Discover, and American Express.

I have read and fully understand the financial policy set forth by the office and I agree to the terms of this policy.

Patient Name: _____

Patient Signature: _____ Date: _____