FINANCIAL POLICY

PATIENT'S NAME: _____ **DATE: _____**

At Precision Dental, we are committed to providing you with excellent patient care, and we appreciate your choice in our office. We welcome you to our office, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

INSURANCE: All insurance information must be registered at the initial appointment and updated when needed. Precision Dental provides insurance company billing as a *courtesy* to our patients. Please understand that your insurance policy is a contract between you and your insurance company. Precision Dental is not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance. We can submit a pre-estimate of benefits from your insurance if you request to do so. Routine treatments are generally performed without submitting a request of pre-estimate of benefits. The patient portion of particular dental service(s) is estimated and due at the time of service, OR the patient can sign a credit card authorization to bill their credit card AFTER insurance has paid for the visit. The claims we submit to insurance companies indicate that you have assigned those benefits to Precision Dental. However, if you are paid by the insurance company instead of Precision Dental, you then become responsible for the total account balance and payment would be expected immediately. The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Precision Dental staff regarding his/her remaining benefit in any such benefit period. You as a patient are always responsible for payment at the time of service and on receipt of a bill for any amount not covered by your insurance. If your insurance carrier denies any part of your claim, or if you elect to continue services past your approved period, you will be responsible for your account balance in full. If the insurance company has not paid the claim within 60 days, the full balance will be automatically transferred to you. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. **Initials:** _____

PAYMENT POLICY: The patient is responsible for full payment due at the time of service as well as on receipt of a bill for the balance due of services provided. Payment arrangements may be made with the Front Office requiring a credit card authorization to bill for services. For patients without dental insurance, a down-payment is required in order to schedule for any appointment. All procedures involving lab work will require 50% down payment, then the remaining 50% balance will be due as treatment progresses. The balance must be paid before final insertion. If you are having extensive treatment over a period of time, we request payments during the course of treatment. Parents not accompanying their child to an appointment must make PRIOR arrangements for payment (cash, check or credit card authorization). Parents accompanying their children are financially responsible for payment. Precision Dental will assess a finance charge of 1.5% per month (18% annually) on all accounts overdue more than 45 days from the date of billing. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $35.00. I understand if my account should become delinquent and sent to the collection agency, I will be responsible for all reasonable collection costs. Also, if a patient's account is sent to collections, Precision Dental will not provide any treatment until the account is current. Failure to pay for services in a timely manner may jeopardize a patient's access to routine dental care. If my account becomes 90 days past due, the account may be handed over to our collection agency. I agree to be responsible for all costs of the collection process, as well as my portion of the dental services provided to me. **Initials:** _____

MISSED APPOINTMENTS, CANCELLATION, & NO-SHOW POLICY: When you make an appointment we reserve that time for you. We understand that unavoidable emergencies or circumstances do arise which may require you to cancel your appointment. Unless cancelled at least *48 hours in advance*, our policy is to charge for missed appointments at the rate of $50. If you are unable to keep your scheduled appointment, please notify us in advance so we can accommodate our other patients. You may also reschedule your appointment at that time. Please help us service you better by keeping scheduled appointments. If we do not receive notice of your cancellation with a 48 hour notice, your account will be assessed a $50 cancellation fee for the office visit.
Our no-show policy is as follows: a 48-hour notice is required, or there will be a charge for missed appointments of $50 for the time slot we were not able to fill when you were a no-show. After the first no-show appointment you will receive a phone call to remind you of the missed appointment, cancellation fee, and to reschedule your appointment. After the second no-show you will be charged the $50 cancellation fee, and will be required to hold subsequent appointments with your credit card information. On the third no-show, it will be the dentist's discretion as to whether a discharge letter will be sent out disengaging you from the practice and giving you 30 days to enroll with a new dentist. **Initials:** _____

AUTHORIZATION AND RELEASE & RECEIPT OF NOTICE OF POLICIES: I authorize and give my consent for treatment to Precision Dental to perform diagnostic procedures and treatment as may be necessary for proper dental care. I understand I will be informed if there is a need for change of treatment and I agree to be responsible for the work actually completed. I authorize Precision Dental to submit claims (on my behalf) to insurance and to disclose health information to the extent necessary for the purpose of evaluating and administering claims for insurance benefits. Also, I assign benefits paid by insurance directly to Precision Dental. I HAVE READ AND UNDERSTAND Precision Dental's INFORMED DENTAL CONSENT, FINANCIAL POLICY, and APPOINTMENT POLICY. I understand and accept responsibility of cooperating with these policies. I understand that I will be responsible for financial balances resulting from treatment received. My signature below indicates that I have reviewed a copy of Precision Dental's Informed Dental Consent, Financial Policy, and Appointment Policy. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

Patient or Responsible Party Signature _____ **Date** _____

Relationship to Patient: (Self, Parent, or Guardian) _____