DAVIS
FAMILY DENTAL

OFFICE AND FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care and personal attention. Everyone benefits when office and financial policy arrangements are understood. In order that we have a definite understanding to the payment for dental services, the following is our policy.

Payment is due at the time service is provided. We accept Cash, Personal checks, Cashier's checks, Money orders, Visa, MasterCard, Discover, American Express and Care Credit. Returned checks will be subject to additional fees.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payments, which is the **estimated** amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Once insurance has paid their share, a statement will be sent to you for any remaining balances and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collections process.

Cancellations & No Show Policy: Your appointment time is reserved for you. For cancellations we request **24 hours** advance notice. Your account will be charged a broken appointment fee of **$50.00** for a **no show** appointment. An answering machine is available for messages left after business hours.

Delinquent balances over 60 day will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement. **Account over 90** days will be turned over to collections, you will be responsible for all costs of collections including, but not limited to, agency fees, attorney fees, rebilling charges and court costs.

CONSENT: I HAVE READ, UNDERSTAND AND AGRRE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFTIS DIRECTLY TO MY DETNAL OFFICE. The undersigned hereby authorize the presiding Doctor and/or staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the presiding Doctor and/or staff to make a thorough diagnosis for the patient's dental needs. I also authorize the presiding Doctor and/or staff to perform any and all forms of treatment, medications and therapy that may be indicated, and agreed upon. I also understand the use of anesthetic agents embodies a certain risk.

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Signature (Patient for responsible party) **Date**