



Page Family
-DENTISTRY-

FINANCIAL POLICY and AGREEMENT

Policy

Thank you for choosing Page Family Dentistry as your dental health care provider. We are committed to providing you with the highest quality dental care. Following is a statement of our financial policy which we require you to read, agree to and sign prior to any treatment. We thank you for the opportunity to serve you and welcome any question you may have concerning our financial policies.

- Payment and/or co-pay for services is considered a part of your treatment and is due at time of treatment
- For co-pays of \$250 or more, payment is due to secure the appointment time
- Forms of payment include: Cash, Personal Check, MasterCard, Visa, Discover, American Express, HSA, and Health Benefit Savings card. Credit and Debit cards will have a 3.5% convenience fee added.
- We offer third party financing options; approval is granted solely by the crediting company
- We offer a very affordable in-house Discount Plan, detail available upon request
- Returned checks are subject to additional fees, up to \$50
- A \$75 fee may be applied for appointments canceled/broken with less than 24-hour notice.
- Should it become necessary to enlist a collection service and/or legal assistance in collecting monies due to abundant dental care, you will be responsible for any collection and/or legal charges

Dental Insurance Overview

As a courtesy, we will assist with the processing of all insurance claims. We will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. We will strive to provide an accurate estimate; however, your insurance company and your plan benefits are ultimately determined by the carrier.

All charges incurred are your responsibility, regardless of insurance coverage. As your dental care provider, our relationship is with you - our patient - not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is party to that contract.

Our practice is committed to providing the best treatment for all patients and we will charge what is usual and customary for the local market. You are responsible for payment regardless of any company's arbitrary determination of usual and customary fees.



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Insurance payments are ordinarily received within 30–60 days from the time of filing. If your insurance company has not made payment within 45 days, we will ask that you contact your insurance company to obtain an expected payment date. If payment is not received within 60 days of the filing date, and/or your claim is denied, you will be responsible for paying the amount in full immediately. Any amount not paid will be subject to 18% interest per annum. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance over any claim.

To pursue treatment, your signature is required on this form as well as any other forms required by your insurance company.

Agreement

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental health benefits directly to my dental office. I understand that the responsibility for payment for dental services provided by this office for myself or my dependents is my own, and/or attorney fees will be added to any overdue balance that requires collection initiatives.

I understand that in the absence of prompt payment, my personal and financial records concerning these professional services will be released to Page Family Dentistry's legal representatives for collection. The legal representative will act as the providers "business associate" in compliance with the federal Health Portability and Accountability Act.

By signing below, I am authorizing Page Family Dentistry to call me at any number provided. I also agree to any fees or charges that you may incur or for incoming or outgoing calls, to or from any such number, without reimbursement.

Patient's Printed Name

Date

Signature