Florissant Dental Care

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Please note that payment of your bill is considered part of your treatment. Payment is due at the time service is provided. Our office accepts Cash, Checks, Matercard, Visa, Discover. Outside financing is available upon request and approval. Please note: Return checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistant, you will be responsible for any collection and/or legal charges up to 40%

Do you have insurance?

( ) As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will of course do all we can to make sure your estimate isa accurate as possible.

( ) All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you our patients not with your insurance company. Your insurance policy is contracted between you, your employer, and your insurance company. Our office is not a party that contract.

( ) Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

( ) We ask you to sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

( ) We ask you to pay the deductible and co-payment which is the estimated amount not covered by your insurance company, at the time of service.

( ) I understand that I must give 48 hour notice if I need to change or cancel and appointment .If not I will be charged a $35 fee or 10% of the scheduled appointment which is greater.

( ) I understand that if I am taking advantage of a coupon that includes dental x-rays there will be a $50 charge to have them copied or transferred.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibly for payment for Dental Service provided in this office for myself or my dependents is due and payable at the time of service are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney will be added to any overdue balance.

Patient Signature (Guarding if Child _____ Date_____