FINANCIAL POLICY FOR FULL HEART DENTISTRY.

Please read this entire document carefully. You must sign this form before we proceed with your care. Please address any concerns to our financial coordinator.

Our primary goal is to provide the highest quality oral health care, and in a gentle, efficient and enthusiastic manner. We will do our best to help you plan on your investment in your dental health based on your individual treatment plan. You'll be given an estimate of your next visit's total cost. Most estimates we provide are quite accurate unless we find unforeseen and sudden changes in your dental treatment.

Please bring cash, check or credit card with you at the time of treatment. If you cannot provide immediate payment for services rendered, please ask our Financial Coordinator ahead of time to see if you may qualify for other payment options.

Your account must be cleared within 30 days of treatment or before your next appointment, whichever comes first. Appointments for non-emergency treatment may need to be postponed pending payment of outstanding balances. Amounts due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month in addition to a $5.00 monthly billing fee per statement.

Delinquent balances over 90 days old will be sent to our collection agency or to small claims court for collection at our discretion. PLEASE NOTE THAT YOU WILL BE RESPONSIBLE FOR ALL FEES INCURRED IN THE ATTEMPT TO COLLECT ON YOUR ACCOUNT. At this point you may receive a letter advising you to seek treatment from a different provider. Please understand that if a patient decides to discontinue treatment after it has been started, a refund will not be given. Individual circumstances may be discussed with the Office Manager.

A returned check fee of $40.00 (subject to change as bank fees increase) will be added to your account for any returned check. Before we accept another payment by check, the $40.00 fee plus full payment for the check that did not clear must be paid in cash, or credit card.

Missed/ Cancelled/ Broken appointments

We REQUEST 48 hours advance notice for rescheduling your appointment. Missed appointments will add to the cost of dental care when reserved facilities are left waiting empty. We understand that certain unforeseen circumstances may arise they can be discussed with the Office Manager.

Your account will be charged a broken appointment minimum fee of $50.00 for a scheduled missed appointment without proper notification. **Penalty fees are higher for missed appointments** longer than one hour: over an hour up to 2 hours will be charged $75.00; over 2 hours will be charged $100.00.

OFFICE POLICY FOR PATIENTS WITH DENTAL INSURANCE

Please bring your insurance card and any other information you may have from your insurance carrier to each appointment. Also, please let us know immediately of any changes in your insurance carrier or policy.

Your treatment plan is individually based on one's diagnosis, and is not based on your dental insurance benefits or lack of benefits.

We will always do our best to help you to maximize your insurance benefits.

Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer and your insurance company. We may or may not be a participating provider for your insurance carrier.

Not all services are a covered benefit in all contracts. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed by your employer or group plan administrator. **We cannot act as a mediator with the carrier or your employer.**

As a courtesy to all of our insured patients, we will file your dental insurance claim forms. You are responsible on the day of treatment for any uncovered expenses associated with the treatment rendered at the visit. In such cases, you are also responsible at the time of treatment for payment to us of any applicable deductible as well as for your portion of treatment. If the insurance carrier sends payments to you, payment is expected in full at time of service unless other arrangements have been made prior. Monthly accruing interest at the rate of 1.5% in addition to a billing fee of $5.00 per monthly statement can be avoided if your personal financial responsibility is clear within 30 days of your treatment, thereby eliminating the associated cost and need for statements to be generated and mailed to you.

Your claim will be filed immediately, and benefits are expected are to be paid within 30 days. The filing of an insurance claim does not relieve you of your responsibility on your account. If the claim is not cleared by your carrier in 45 days, the unpaid portion will be your responsibility. A statement will be issued to you for the unpaid portion, accumulate interest at the rate of 1.5% per month with the billing fee of $5.00 per monthly statement. (Please feel free to call your insurance company for prompt payment on your claim).

(Below, please initial as appropriate, sign and date.)

[_____] I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment rendered to avoid any additional fees. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s).

X_____ _____ (_____)

PATIENT (or parent of minor) SIGNATURE DATE FOR STAFF USE

x_____

PLEASE PRINT NAME