



### FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and pleasing atmosphere. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards (Visa, MasterCard, and Discover). New patient emergency visits must be paid in full at the time of the appointment.
2. As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for reimbursement or you may assign the payment to our office and we will file the primary insurance for you. **Secondary insurance will be filed only if the correct information is provided at the time of service.**
3. You must provide the office with correct **dental** insurance information at the time of the service to include the mailing address, phone and group number. If insurance coverage cannot be verified you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.
4. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and **estimated** co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fees schedule. Any remaining balances will be billed to you after a claim is paid.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the type of plan purchased by your employer and is not related to our professional fees.
5. Past due accounts will be notified via statement notes. If the account remains unpaid, we will be required to employ a collection service to collect payment. There is a **\$5.00 per month late fee for accounts over 60 days**. The responsible party agrees to pay all related collection fees. There is a **\$35.00 service charge for all returned checks**.
6. Our office will make every **reasonable** effort to obtain payment from your insurance company. If the claim remains Unpaid after 120 days, you will be responsible for the remaining balance. Any additional insurance appeals will become your responsibility. We will be happy to provide you with any necessary forms or receipts.
7. **The parent or guardian who brings the child for an initial visit is the responsible party. This parent is Required to pay for services rendered regardless of what a divorce decree may state.**

### AUTHORIZATION

1. I authorize Dr. Doss, Dr. Stroud, and staff to release any information concerning my case to my insurance company.
2. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

\_\_\_\_\_  
PATIENT NAME(S) (PLEASE PRINT)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PARENT OR RESPONSIBLE PARTY

\_\_\_\_\_  
PRINT NAME OF RESPONSIBLE PARTY