

FINANCIAL POLICY

We are committed to providing you with high quality dentistry in a safe and caring environment for a fair fee. We would like to assist you in optimizing the benefits you obtain from your insurance carrier, and in minimizing your concerns about the cost of services you receive. In order to achieve these goals, we need your assistance and your understanding of our payment policy. The following is a statement of our Financial Policy which we require you to read and sign prior to any dental services being rendered.

INITIAL VISIT. Payment, in full, for initial visit charges is due on the day services are rendered. Any insurance benefit for this visit will be paid directly to you by your insurance carrier. We accept CASH, CHECKS, DEBIT CARDS, MASTERCARD and VISA.

INSURANCE. Insurance benefits from your Primary Insurance Company will be accepted when the following requirements are met:

- 1) You have supplied us with the necessary identification information prior to your appointment.**
- 2) It is verified, by us, that you have current dental coverage.**
- 3) Your insurance company agrees to pay us directly.**

Once your insurance is accepted, our experienced staff will estimate your deductible, and the portion not covered by your insurance. We require full payment of your estimated portion on the day services are rendered. This applies to dependent children unaccompanied by an adult as well. We suggest parents file a credit card number with us to use for their dependents when they are unaccompanied by an adult. Our estimates are subject to final approval by your insurance company. Therefore, the amount due our office is subject to change.

Please understand that your dental benefit program is a contract between you, your employer, and the insurance company. We are not a party to that contract. Not all dental services are covered under your insurance benefits. You, not the insurance company, are responsible for all services rendered to you and your dependents. We are not responsible for any exclusions that may cause your claim to be denied in full, or in part. Our office files your insurance, and extends credit to you while waiting for payment, as a courtesy to you. **Claims not paid for by your insurance carrier after 60 days of filing, automatically become your responsibility, and you will receive a statement for that balance.**

This policy also applies to any changes in your present insurance coverage as well.

MISSED APPOINTMENTS. Please consider your scheduled appointments carefully. We require a 24-hour cancellation notice. Reminder calls made on your behalf is a courtesy we extend to you. However, you, the patient, are responsible for knowing and keeping scheduled appointments for you and your family members. We do ask that you return our calls with a confirmation of your appointment. You can leave your confirmation on our answering machine provided for your convenience should you reach us after business hours.

We reserve the right to charge for all cancellations made less than 24 hours in advance. The fee charged is made in accordance with the type of appointment missed.

The **fee** for a missed appointment with **Dr. Chamberlain** is **\$125.00 per hour.**

The **fee** for a missed **Hygiene** appointment is **\$80.00.** These fees cannot be charged to your insurance company.

OFFICE FEES. A check presented for insufficient funds incurs a processing fee of \$30.

PAYMENT PLANS. Payment plans for extensive treatment plans may be available, and must be arranged in advance of any scheduled appointment with our Office Manager.

Thank you for understanding the necessity of our Financial Policy. The best dental health services are based on a friendly and mutual understanding between provider and patient.

I HAVE READ, UNDERSTAND AND AGREE TO ABIDE BY THE STATEMENTS OUTLINED ABOVE.

Signature of Patient/Parent/or Guardian

Print Name

Date

Dependents: _____