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FINANCIAL POLICY

Welcome to our practice. We appreciate the opportunity to provide you with specialized care. Please read this information about our financial and billing policies.

If you do not have insurance, you must pay at the time of service. We accept cash, personal checks, MasterCard, Visa and Discover.

If you have dental insurance, we will file your insurance as a courtesy to you but we request that you pay your estimated portion when services are rendered. We need your current insurance card and policyholder information. You will need to authorize payment directly to us. If your insurance requires co-payments, you must pay that amount at the time of service. If your insurance carrier does not remit payment within the required 30 days, the balance will be due in full from you. It is not our policy to contact carriers to establish why they have not paid or why they paid less than originally indicated since we may not be a part of your agreement with your carrier. If you wish to re-bill your insurance carrier we will provide you with a fully itemized statement.

You are responsible for paying us for any services not covered by insurance. Payment is due on receipt of the monthly billing statement. **Even if you have insurance, payment to us is your responsibility.**

You should know the details of your insurance plan. Many insurance plans require you to use certain doctors and may require precertification. We are not responsible if you are sent to the wrong facility.

In case of divorce, the parent bringing the child is responsible for all payments. Our office is not involved in disagreements between the parties in a divorce situation.

You may be billed by other facilities for other services such as lab services if we perform a biopsy.

Accounts not paid in full within 30 days are considered past due. Interest at a rate of 1.0% per month will be charged on all past due accounts (30 days). There is a fee of $30.00 for each returned check and if the account is not paid in full in 90 days it will be turned over to our collection agency.

"I verify the accuracy of the billing information and I realize that the responsibility for all account balances is mine."

Patient Signature _____ Date_____
(Or guardian/guarantor if under the age of 19)

"I authorize the release of any medical information necessary to process my insurance claim and any dispute with the insurance company is no reason for non-payment of this account."

Patient Signature_____Date_____
(Or guardian/guarantor if under the age of 19)