ELEVATE
FAMILY DENTISTRY

# Office Payment, Appointments and Insurance Policy

We strive to provide excellent care, skill and judgment and in return, we ask for your help in paying for our services in a responsible and timely manner.

1. CONTRACTED INSURANCE: All contracted insurance companies are billed directly as a courtesy. We require that the deductible, co-payments and non-covered benefits be paid for on the day services are rendered. In general, benefits should be assigned to us. Insurance policies do not guarantee any payments. The payment toward any charges may vary. Any remaining balance following insurance payments are your responsibility. Payment for this is expected within 30 days from receipt of your statement.

**2. CO-PAYS: All *estimated* patient co-pays are expected at the time the service is rendered.**

3. NON-CONTRACTED INSURANCE: All Third Party Payers (motor vehicle accident insurance, commercial merchants, lawyers) are considered non-contracted.

4. METHOD OF PAYMENT: We accept cash, checks, VISA or MasterCard, Discover and Care Credit.

5. RETURNED CHECKS: There will be a $ 25.00 charge for all returned checks.

6. SERVICE FEE: There is an interest fee accrued on ALL accounts (up to 12% per annum) with balances 90 days and over, regardless of payment arrangements or secondary insurance status. Should the account be forwarded to collection, you will be responsible for all related collection fees and interest added to your account.

7. Patients under the age of 18 MUST be accompanied to their appointment by a parent or guardian unless a prior discussion was had with the Office Manager or doctor.

**8. NO SHOW/CANCELLATION POLICY: There may be a $75.00 PER HOUR fee for no-show appointments or cancellation of appointments without 48-hour notice.**

*I understand that the doctor's office will aid in submitting claims to my insurance company on my behalf. I also understand that I have the final responsibility for payment of all fees for services rendered on my behalf. Unless otherwise noted, I authorize payment of dental benefits to the doctor for services provided to me or any member of my family covered under my insurance plan.*

**I HAVE FULLY READ, UNDERSTAND, AND CONSENT TO ALL OF THE ABOVE TERMS.**

Signed: _____ Print Name _____ Date:_____
(Patient, parent or guardian who is financially responsible for account.)

Front Office Coordinator_____ Date: _____