

Shoreland Dental

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. Our office is committed to providing you with the best possible dental care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and agree to (by signature) prior to receiving any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

We accept the following forms of payment: Cash, Check, VISA, MasterCard, Discover, and American Express.

Payment for services is due at the time treatment is performed unless prior arrangements have been made with the doctor and office manager.

If a denture, partial denture, night guard, crown or bridge is to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first appointment. The remaining balance is required to be paid in full at the time the prosthesis is inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any charges/payment due. For any unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous payment arrangements have been made with the doctor and business manager.

Checks that are returned to our office from your financial institution are subject to a \$30.00 returned check fee. This fee covers the processing fees that are charged to our office and any additional clerical/billing efforts that are required.

Any balance unpaid for 60 days will be subject to a monthly 2% finance charge, unless prior arrangements have been made.

Any balance unpaid for 120 days will be considered in default and sent to collections by a collection agency.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits from your insurance company and your insurance company has not paid your account in full within 60 days of treatment performed, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge the usual and customary fees for our area. You are responsible for payment regardless of your insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are rendered. Insurance claims cannot be backdated. Most benefits will need to be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service.

We will be happy to discuss our charges and how they relate to your particular situation. We do realize that temporary financial situations may affect timely payment of your account balance. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account.

Regarding Cancellations/Missed Appointments

Please notify us 48 business hours in advance if you are unable to keep your appointment otherwise you will be charged as followed:

- First cancelled/missed appointment a \$25 cancellation fee will be applied to your account.
- Second and subsequent cancelled/missed appointments a \$100 per hour cancellation fee will be applied to your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the financial Policy. I understand and agree to this Financial Policy:

Signature of Patient or Responsible Party: _____ Date: _____