Coleman

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FINANCIAL AGREEMENT

Thank you for choosing us to provide your dental care. We consider it an honor to have been chosen by you to do so. Our philosophy in serving people is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement is indicative of our respect for your right to know ahead of time what our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our business office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your dental claims and accept assignment of dental insurance benefits provided you agree to the following:

As a courtesy to all patients we will verify your dental insurance benefits, however, <u>you are ultimately responsible</u> to know your Plan coverage, exclusions and limitations. Furthermore, you should <u>be aware of non-covered benefits</u> such as missing tooth clauses, crown/bridge/denture restorations, bruxism, downgraded limitations for fillings and porcelain on crowns on molar teeth, frequency limits for exams, prophylaxis (cleanings), fluoride and x-rays, etc.

Although we may estimate your insurance benefits, please keep in mind they are only estimates, knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc., is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. All estimates are subject to final approval by your dental insurance plan; therefore the amount due is subject to change after final explanation of benefits have been paid.

The estimated amount not covered by your insurance is due at the time of treatment and maybe paid by cash, personal check, Visa, MasterCard, Discover or Amex. To help you accept an extensive treatment plan, we are offering a Care Credit dental treatment Financing Program.

1. You must provide us with an insurance card and/or all the information necessary to verify your coverage in order to file your dental insurance claim.

2. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.

3. You are responsible for our fees and not what your insurance company allows or considers "usual, customary and reasonable ," all of which vary from one company to another.

4. All charges not paid by your insurance company are your responsibility regardless of the reason for Nonpayment. **Not all the services we provide are covered benefits**. Benefits differ from one plan to another and one company to another. Fees for noncovered services, along with deductibles and copayments are due at the time of treatment. If the insurance company does not pay in full within 30 days, it will be your responsibility to pay the balance due immediately and to assist us in collecting the unpaid balance from the insurance company for you.

PAYMENT POLICY
We accept cash, personal checks, debit cards, Visa, MasterCard, Discover and Amex. We participate with Care Credit as an additional financing option.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian **accompanying** the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment **without any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.**

Initial (____________).

RETURNED CHECKS: A $25.00 charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances. We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt including the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

CANCELLATION POLICY: Our **private practice** is growing as many new patients are discovering our attention to detail and compassionate care, therefore **scheduled appointments are specifically reserved for you**. We will help remind you of your next appointment by contacting your preferred telephone number on record to confirm a scheduled appointment 2 days in advance. If we do not speak with you directly, we will leave a voicemail reminder if available. If you cannot keep a scheduled appointment **WE REQUIRE A MINIMUM OF 48 HOURS ADVANCE NOTICE** from the time of your appointment to cancel or reschedule your appointment. This will allow our office adequate time to provide services for another patient in need. Leaving a message on our office voicemail the night before **does not qualify as a 24 hour notice**; nor does leaving such a message during the weekend for a Monday appointment. We will charge $50.00 for all Broken or Missed appointments.

We take Broken or Missed appointments seriously, so please be considerate and inform us in advance if you need to change your appointment.

Initial (___________)

I have understood and am in agreement to the financial policy of *Coleman Family Dental Care* as stated above.

______________________________ Patient / Guardian

______________________________ Date

______________________________ Staff initials