

# DENTAL DIMENSIONS FINANCIAL POLICIES

Thank you for choosing us for complete oral health care. We have found that our patients appreciate knowing exactly what to expect from us both from a philosophy and financial aspect. Therefore, we prefer to inform our patients of these before we begin any treatment.

Our Vision: Providing complete, life-long dentistry with excellence and integrity while keeping a focus on the whole person.

Financial Arrangements: We offer the following methods of payment for services provided. This will allow us to focus on our specialty, providing you with superior customer service and optimal dentistry in a comfortable environment using up-to-date materials while keeping our fees as affordable as possible.

1. Cash, Check, Debit Card, Mastercard, Visa, Discover & American Express Accepted

Payment in full is due when services are performed unless financial arrangements have been made prior to treatment.

2. Dental Financing Plan

We have made arrangements with a company that will finance your dental work with approved credit. This will allow you to complete your dental work without delay, make no initial payment, and have low monthly payments with interest free options. Application forms are available at the reception desk.

3. Dental Insurance

Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance, is due at the time treatment is performed. Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding dental fees. We will be glad to process your insurance forms at no charge.

4. Dental Insurance Estimates

Based on the information we have from your insurance company, we will ESTIMATE your portion of dental fees and payment will be due at the time of service. If there is a balance due after your insurance company pays their portion, you will be billed for any amount unpaid. You are responsible for any charges exceeding your benefits. Our office will assist in making collections from the insurance company by filing the necessary forms. However, our office cannot render services based on the assumption that charges will be paid by the insurance company.

5. Appointments, Timeliness, and Communication

Please remember that your appointments are reserved specifically for you. We are committed to seeing you on-time and request that you arrive on-time for your visits as well. We want to ensure all patients are seen when promised. We request that at least 48 hour notice be given if an appointment needs to be rescheduled. Missed appointments (no shows) and short notice cancellations (less than 48 hours) are subject to a charge commensurate with the time reserved for treatment (\$50.00 an hour). We prefer open and honest communication in our office, and request your permission to tell you the exact condition of your oral health and to explain the optimal way to treat it.

6. Treatment Fee Estimates

Dental treatment fees given are based on the treatment anticipated at the initial comprehensive examination. Some teeth may have hidden decay or fractures, affected nerves or other unanticipated conditions requiring more extensive dental treatment. In situations where additional charges are involved, we will explain the reason for additional treatment needed. Our financial coordinator will discuss the additional fees and financial arrangements involved.

7. Interest

A 1.5 % monthly interest charge (18% APR) will be applied to ALL BALANCES OVER 30 DAYS PAST DUE.

8. Returned Checks

A \$40.00 charge will be applied to all returned checks.

I have read and understand the information above.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

PRINTED NAME \_\_\_\_\_ SIGNATURE \_\_\_\_\_