

Financial Policy

In order to reduce confusion and misunderstanding between our patients and the office, we have adopted the following financial policy. If you have any questions, please discuss them with one of our patient account representatives. We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, checks, Care Credit, debit cards, and all major credit cards. We also accept health savings account and flex spending accounts of all types.
- Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the dentist. If your insurance company does not pay within a reasonable period, we will look to you for payment. If we later received a check from your insurer, we will refund any over payment to you.
- We have made prior arrangements with many dental plans to accept an assignment benefits. If you are covered by one of these plans, we will bill your plan and will only require you to pay the co-payment of co- insurance due at the time of service.
- All dental plans are not the same and do not cover the same services. In event your dental plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you READ YOUR INSURANCE BOOKLET or a copy of the contract your policy falls under to determine your benefits.
- You will be responsible for promptly responding to your insurance company to provide any additional information they may request regarding your treatment, pre-existing conditions, accidents or other insurance coverage. Failure to respond in a timely manner may result in your account becoming due and payable, in full, immediately.
- Be prepared to present your insurance care and proof of identity (e.g. driver's license) at each visit. You will be responsible for providing a change of address, telephone number and/or insurance information any time a change occurs.
- A prepayment of your deductible and coinsurance will be required for your portion of our fees, based on our contract allowable fees. Any balance remaining, after your dental plan pays, is your responsibility. Payment is due upon receipt of a statement from our office.
- Please be aware of the following dental records related fees for the purposes of transferring records: CD of Images - \$10
- We will look to the adult accompanying a minor for payment of all services rendered to minor patients.
- Please be advised that any appointment canceled with less than 48 hours notice will be subject to a \$50 cancellation fee. If you have any questions about an appointment, please call to ASAP to avoid any potential problems.
- **I have read and understand the financial policy outlined above, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by Kohlers Crossing Dental.**

Patient Name: _____

Patient Signature: _____

Date: _____