FOX POINT DENTAL - FINANCIAL AGREEMENT

Insurance

If you have dental insurance, we are eager to help you receive your maximum allowable benefits. In order to achieve this goal we need your assistance and your understanding of our payment policy.

You will be asked to update your personal and insurance information periodically, including providing our office with copies of your insurance card. We are required by law to obtain your signature for permission to release information to your insurance carrier. We will gladly submit fees for your covered dental services to your insurance company. However, we expect payment of all services within 90 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 90 days.** It is your responsibility to understand your coverage and benefits, including pre-authorizations and authorization requirements. We will, however, assist you to ensure that all plan requirements are met.

_____**Please initial**

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

_____**Please initial**

PAYMENT FOR SERVICES

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance. We accept cash, checks, MasterCard, Visa and Discover.

_____**Please initial**

Returned checks will result in a $35 fee that will be posted to your account. Returned checks, balances older than 90 days and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees.

_____**Please initial**

We will attempt to give you an estimate of your patient payment. This estimate may be altered by your insurance plan, as it is subject to annual deductibles, maximums, waiting periods etc. However, regardless of an estimate that you may have received, any difference between the fee charged and the amount paid by the insurance company is your responsibility.

_____**Please initial**

GENERAL

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as a dental care provider, our relationship is with you, not your insurance company.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

CANCELLED APPOINTMENTS

Charges may be incurred for broken, confirmed appointments and appointments cancelled without 24 hour notice. Your cooperation in cancelling your scheduled appointment well in advance allows us the opportunity to offer your appointment to a person who needs dental care. **Failure to show for a scheduled, confirmed appointment may result in a $45 cancellation fee.**

_____**Please initial**

If you have any questions about the above information, please do not hesitate to ask us.

Thank you,

Fox Point Dental LLC

My signature below constitutes acknowledgement and acceptance of this policy.

Patient name-Printed_____

Patient or guardian signature_____

Date_____