304 S. CLAIRBORNE ROAD, SUITE 100
OLATHE, KANSAS 66062
TELEPHONE (913) 764-6367
FAX (913) 764-6387

FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. 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 that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

- Please bring your insurance card with you to your appointments. If your insurance company/coverage changes, it is your responsibility to inform us of the change.
- All charges are your responsibility. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments, are due from you at the time of treatment.
- If the insurance company does not pay in full within 30 days, we may ask you to contact the insurance carrier. If your insurance does not pay in full within 45 days, we will require you to pay the balance due with cash, check or credit card.
- If we do not have a contract with your insurance company, you will be required to pay for your visit.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

- FULL PAYMENT is due at the time of service. If insurance benefits apply, estimated patient co-payments and deductibles are due at the time of service, unless other arrangements are made.
- RETURNED CHECKS are subject to a $50 return check fee. You are responsible for any collection fees, legal fees, or court costs that may occur.
- UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.5% . If payment is delinquent, the patient will be responsible for payment of collection, attorney's fees, and court costs associated with the recovery of the monies due on the account.
- We understand that temporary financial situations may affect timely payment of your balance. We encourage you to communicate such problems (before your bill becomes past due) so that we may assist you in the management of your account.
- We are proud to offer financing through Care Credit.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation or need to reschedule 48 hours in advance, you will be charged $70.00. Please help us maintain the highest quality of care by keeping scheduled appointments.

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Printed Name of Patient

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Signature of Patient or Legal Guardian

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Date