CEDAR PLACE DENTAL
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FINANCIAL RESPONSIBILITY ACKNOWLEDGEMENT

Each patient is responsible for his or her own bill. As a courtesy, we will submit your claim to the insurance company. Because of the vast array of insurance plans and processes, however, we are not responsible for knowing your specific insurance benefits and limitations. We will help where we can, but you must know important issues such as co-pays, deductibles, annual maximums, etc.

Other Insurance Matters:

- 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. <u>Fees for these services, along with unpaid deductibles and co-payments, are due from you at the time of treatment.</u>
- 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:

- Payments for services are due at the time services are rendered. We accept cash, check, Visa, MasterCard, and Discover.
- 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.
- 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.

Appointment Cancellations:

- Please notify our office 48 hours in advance if you must miss, reschedule or cancel your appointment. Failure to do so will result in a $70.00 missed appointment fee and may prohibit our being able to schedule future appointments with you.

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Printed Name of Patient | Signature of Patient or Legal Guardian

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Date