Barry G. Sorenson
Family Dental Care
Financial Policy

Thank you for choosing Family Dental Care as your dental care provider. We are committed to your treatment being successful. The following is an outline of our "Financial Policy." It is our intention to inform our patients as clearly and completely as possible as to our guidelines of payment for services rendered. It is our hope that openly discussing our financial policy will prevent future financial misunderstandings.

Payment Policy:

Payment is due at the time of Service.

If you are unable to pay at the time of service, your appointment will need to be rescheduled. We take VISA, Mastercard, American Express, Discover, cash, personal checks or CARE CREDIT.

Insurance and Insurance Collection:

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers routinely stall, deny, and reduce payments. To that end, our billing staff has undergone training to maximize your insurance reimbursement, while reducing the time by which they pay.

Please note that we can only ever give you an estimate of how your insurance will pay on your behalf, and that you are ultimately responsible for knowing and understanding your Dental Insurance Plan. We are more than happy to bill your insurance as a courtesy to you. In the event that your insurance company does not reimburse within 60 days, the balance will be your responsibility.

Secondary Insurers:

Having more than one insurer DOES NOT necessarily mean that your services will be covered at 100%. Secondary insurers will pay only a certain percent based on what your primary insurance has paid. We may bill your secondary insurance carrier as a courtesy; however, you are responsible for any outstanding balances after your insurance(s) have paid.

UCR, or Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and *we charge what is usual and customary in our area*. You are responsible for payment regardless of the insurance company's arbitrary determination of usual and customary rates.

Divorce Decrees:

This office is not a party to your divorce decree. Adult patients are responsible for their bill at the time of service. The responsibility for minors rests with the accompanying adult. We will not collect separately from each parent.

Returned checks:

Any returned checks will be billed back to your account with a $25.00 service charge. We do not automatically re-deposit NSF checks without first speaking to the patient.

Finance Fees:

We are not a billing company. We reserve the right to charge interest in the amount of 1.5% as provided by state law.

Appointments:

Please remember that once an appointment has been made, *this time is reserved specifically for you.* We kindly request at least 24 business hours' notice should you have to reschedule or cancel an appointment. Missed appointments are subject to a $75.00 fee.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree with this financial Policy.

Signed_____ **Date**_____
(Patient or Responsible Party)

Signed_____ **Date**_____
(Co-Responsible Party)

FINANCIAL CONTRACT/AGREEMENT

1. I understand that if I do not pay my account with Family Dental Care in full that my account may be assigned to a collection agency for collection.

2. I understand that if my account is assigned to a collection agency, that the collection agency will charge a commission or fee that may be as much as 40 percent of the amount I owe to Family Dental Care. I agree that if my account is assigned to a collection agency that Family Dental Care may add the amount of the Collection Agency's commission or fee to the amount that I owe, and I agree to pay that additional amount.

3. I understand that the addition of a collection agency's fee or commission to my unpaid balance may well result in my owing a sum substantially in excess of the amount owed for dental services. I understand, for example, that if the unpaid balance that I owe to Family Dental Care is $1,000.00, that Dr. Sorenson may add up to $400 to my account, and I agree to pay the sum of $1,400 in such event.

4. I understand and agree that in the event legal action is commenced to enforce my obligations hereunder, that I will pay court costs and reasonable attorney's fees.

_____ _____

Signature of Patient or Guarantor Date