PHOENICIAN DENTAL CENTER

FINANCIAL POLICY

Our office wants all of our patients to be able to comfortably afford dental care. We proudly offer the following policy so that you can have the opportunity to decide which payment option best suits your needs.

Insurance:
Our office understands the value of insurance benefits to our patients and will gladly work with you to help get the maximum benefit available to you. We will **estimate** your deductible and the portion that is covered by your insurance carrier. The amount that we have determined not to be covered by the carrier is due at the time of treatment and may be paid by any of the options listed below. **Our estimates are subject to final approval by your insurance company and could therefore change the amount due to our office.**

Payment Options:

1. Prepayment of treatment in full using cash or check.

2. Credit Cards- Our office accepts American Express, Discover, Visa, or MasterCard.

3. Financing. Upon qualifying you will be extended a line of credit by an outside financing company. The qualification process is simple and can usually be completed within 10 to 20 minutes.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually), late fees and any other cost that may be incurred to enforce collection of any amount outstanding.

Due to the popularity of our state-of-the art dental office our appointment times have become extremely treasured. Our time, as well as our patients' time is respected. Therefore, we reserve the right to charge for appointments cancelled or broken without 24 hours advance notice at the rate of $25.00 per an hour scheduled. Any appointment scheduled for you that may take 3 hours or longer will be charged at the rate of $100 per an hour.

We would be happy to work with you to plan out the most appropriate arrangements for your budget. Financing your treatment allows you to start your dental care immediately and spread the payments over a period of time. Most importantly, it offers you the opportunity to enjoy the benefits of your dental health without the financial strain. We are committed to providing you with the most positive experience in dental care.

_____ _____
Patient/Responsible Party Signature Date

Patient Name:_____

PHOENICIAN DENTAL CENTER

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have to our practice is to pay for your treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

- We require you to sign this form and or any other necessary documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

- We require you to pay the estimated co-payment, which is the amount not covered by your insurance company, at the time we provide service to you.

- Insurance payments ordinarily are received within thirty to sixty days from the time of billing. If your insurance company has not made payment to our office within sixty days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payment made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE CONDITIONS. I HEREBY AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____ _____

Signature of Patient/Responsible Party Date

Name of Patient:_____