HOMETOWN FAMILY DENTAL
26 SOUTH MAIN STREET
ALBIA, IA, 52531
641-932-2729

FINANCIAL POLICY

Patient Name: ___________________________________ Date of Birth: __________________

Thank you for choosing Hometown Family Dental as your dental healthcare 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 you read and sign prior to any treatment. It is our hope 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 be aware some or perhaps all of the services provided may or may not be covered by your insurance policy.

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.*

Dental appointments scheduled for 90 minutes or longer may require a down payment at the time the appointment is scheduled. The down payment will be dependent upon treatment being performed. The down payment will be credited towards the treatment performed during the appointment. However, if you, the patient, late cancels or no shows at this appointment, the down payment will not be credited towards treatment.

***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.**

We accept cash, check, Visa, Mastercard, or Discover.

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Third-party financing through CareCredit is possible if you would like to pay your balance over time. This option offers flexible, monthly payment plans which can be used immediately and provides benefits to you that we are not able to offer previously. These options range from revolving credit lines to fixed payment loans with interest up to 36 months for qualified patients. If you are interested in learning more about CareCredit, please let us know and we will be happy to assist you.

UNPAID BALANCE over 90 days will be subject to a monthly interest of 1.0% (APR 12%).

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.

Minors Accompanied by Parent or Legal Guardian

The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service.

Unaccompanied Minors

The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Divorce

In the case of divorce or separation, the parent authorizing treatment for a minor will be the person responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Patient / Parent Name Printed:____ **Date:** ______________

Patient / Parent Signature:____ **Date:** ______________
(Responsible Party)