ELSNER FAMILY DENTISTRY

OUR FINANCIAL POLICY

Thank you for choosing **Dr. Elsner** as your Dental Provider. We are committed to providing you with the best possible dental care. Please understand that payment of your bill is considered a part of your dental care. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.
All patients must complete our Patient Information form before seeing the doctor.

***IF YOU HAVE INSURANCE, FULL PAYMENT OF DEDUCTIBLES AND/OR CO-INSURANCE IS REQUIRED AT THE TIME SERVICES ARE RENDERED.**

*WE ACCEPT **Personal checks, MasterCard, Visa, Discover, American Express and Care Credit.**

***FULL PAYMENT IS DUE AT TIME OF SERVICE.**

Regarding Insurance

We will do everything possible to help you understand and make the most of your dental insurance benefits. Please remember that your account balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information and complete the assignment and release section of your Patient History Form. Your insurance policy is a contract between you, your employer and your insurance company. **We are not a party to that contract.** If your insurance company has not paid your claims within 45 days, the balance will be your responsibility. Please be aware that some, and perhaps all, of the services provided may be non-covered services and will be your financial responsibility. **All co-insurance and deductibles are due at the time of treatment.**

Usual and Customary Rates

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

Adult Patients

Adult patients are responsible for full payment at time of service. We reserve the right to charge $25 for returned checks.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa/MasterCard, or payment by cash or check at time of service has been verified.

Missed appointments

Unless cancelled or rescheduled, at least 24 hours in advance, our policy is to charge $50 for missed appointments. Please help us serve you better by keeping scheduled appointments.

Interest/Collection Fees

We reserve the right to charge interest in the amount of 1.5 % as provided by state law for account balances over 30 days. You are also responsible for all expenses and fees, including, but not limited to legal or collection fees incurred by this office in collecting the balance of your account.

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

X _____ Date _____

Signature of Patient or Responsible Party