

FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. **It is our policy to make definite financial arrangements with you before any treatment starts.** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, debit cards, and credit cards (VISA, MasterCard, Discover and CareCredit).
2. For new patient emergency visits we require payment in full at the time of the appointment.
3. As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file the insurance for you. **The office will accept assignment for only the primary insurance coverage**, secondary insurance coverage must be paid to the patient.
4. Our office will file your insurance a maximum of **two times** per appointment.
5. **If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.** We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.
6. You must provide the office with a dental insurance card with the proper mailing address of the insurance company, or provide a dental claim form, which is provided by the employer. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.
7. We accept assignment of benefits for a select group of insurance companies; however you will still be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor. We do not allow insurance companies to dictate our treatment planning, but rather what is in the best interest of the child. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.
8. **The office cannot carry balances longer than 90 days;** regardless if the insurance payment is still pending. A \$5.00 monthly re-billing charge will be added to your account if it is not paid within 60 days, regardless of balance amount.
9. After 90 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will be required to send your account to small claims court to collect payment. The responsible party agrees to pay all reasonable, related collection fees.
10. There will be a \$30.00 service charge for all returned checks.
11. **The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.**

AUTHORIZATION

1. I authorize Dr. Rhodes and staff to release any information concerning my case to my insurance company.
2. I have read & accept the above Financial Policy, understand it & agree to the terms set forth regarding payment.

Signature of Parent or Responsible Party

Date