Dickey
FAMILY DENTISTRY

Family * Cosmetic * Implant Dentistry

A Word About Our Financial Policy

The goal of our office is to extend the finest diagnostic, preventive, and restorative dental care in a professional and compassionate manner. Our greatest concern is your complete oral health. Anything we do or say will be centered on that philosophy. It is recommended that each patient is seen every six months (or as needed) to ensure this preventive philosophy is met. We are committed to your treatment being successful, and to the return and maintenance of your good oral health. We consider the Federal Guidelines of infection control of extreme importance and observe them to the highest standards possible. In order to achieve these goals we must deal with the patient's responsibility to adhere to certain policies.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

I. Payment for Services

A. Payment for services is due at the time services are rendered. We accept cash, checks, and for your convenience, MC/Visa, Discover, and American Express. We will be happy to help you process your insurance claim for your reimbursement as long as we have correct insurance information.

B. Please understand that we are not a financial institution and, therefore, we have no extended payment plans. For your convenience, as an option, you can apply for an extended payment plan through **Care Credit**. (*Please let us know if you are interested in this option.)*

II. Insurance Coverage

Your insurance policy is a contract between you and your insurance company. We will file your insurance claim with your primary insurance carrier. However, your co-payment/co-insurance/deductible is expected at the time services are rendered. Please keep in mind that some, and perhaps all, of the services are not considered reasonable and necessary under the provisions of your insurance plan. We are considered out of network on some insurance companies. This office cannot render services on the assumption that our fees will be paid by your insurance company. All secondary insurance coverage is to be filed by our patients. **Please present the receptionist with a copy of your insurance card and drivers license at check in.**

We invite your to inquire about charges and your financial responsibility prior to services. While we attempt to verify dental benefits, you are ultimately responsible for verifying your insurance coverage. A dental deposit is required on the day services are rendered and will be discussed with you at such a time by our patient accounts department. After insurance is received and if your account is paid in full, a refund of any overpayment will be mailed to you as quickly as possible. If your insurance company has not paid your balance in full, the balance will automatically be transferred to your account, and you will be responsible for the balance owed.

By signing below I acknowledge that I have read and fully understand this financial policy as well as the HIPPA notice. *I assume full responsibility for any balance owed after my insurance plan has paid or denied any charges.* **If my insurance carrier does not make payment within 45 days, I understand that I am responsible for the balance owed on my account.**

Returned checks and balances older than 60 days may be subject to additional collection fees and/or interest charges.

Please note that, unless cancelled at least 24 hours in advance, there may be an office charge for missed appointments. Please call if you need to reschedule.

Signature_____ **Date**_____