

Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is necessary in order for us to provide treatment.

Patients with Dental Insurance

As a *courtesy* to our patients, we prepare and process all insurance forms. However, having insurance does not release the patient from responsibility. Our expectations of you as the owner of the policy are as follows:

1. Estimated patient portions must be paid at the time of service. This may include co-payments, deductibles, co-insurance and/or non-covered procedures.
2. You are responsible for educating yourself about the details of your policy which includes deductibles, yearly maximums, and policy exclusions.
3. If the insurance company does not pay our office within 60 days, it is your responsibility to pay using one of the payment methods listed below. The insurance policy belongs to you and we have no leverage to obtain payment.

A finance charge of 1.5% per month (annual percentage rate 18%) will be assessed on any unpaid balance over 60 (sixty) days regardless of insurance estimates. Insurance estimates are based on **limited** information provided to our office by your insurance company and is not a guarantee of coverage or payment.

Patients without Dental Insurance

If you have no insurance coverage, **full payment is due at time of service** with one of the payment methods below:

Payment Options

For your convenience, you may choose any of the following methods of payment:

- Cash
- Personal Check
- Visa, MasterCard, Discover, American Express – Credit or Debit
- Extended Payment Plan with our Financing Partners: Care Credit

Broken & Missed Appointments

Please make every attempt to keep your scheduled appointments. If you must cancel or reschedule, kindly notify us at least 48 hours in advance. **There is a \$36 charge for all appointments that are broken or missed** without a 48 hour notice.

Minor Patients

The parent, guardian or adult accompanying and signing all forms for a minor will be responsible for full payment. Parents of guardians must be present to authorize all dental treatment to minors.

Financial Agreement

I understand that I am financially responsible for all charges incurred by my dependants, or myself whether or not covered by insurance. I hereby authorize the office of Comfort Dental of Clinton to use the following signature for proof of signature on insurance claims forms for assignment of insurance payments and release of information. I agree to pay Comfort Dental of Clinton for professional services rendered to me at the time of service. If my insurance pays less than estimated, I agree to pay any remaining balance within 30(thirty) days of billing. I expressly agree to pay all costs of collection agency fees assessed at 33% of the total amount due, and all court costs and attorney fees, if these terms are not met.

Patient Name _____

Print Name
(Patient, legal guardian or authorized agent of patient)

Signature

Date