

## Financial Menu

Thank you for choosing our practice for your family dental care. Our goal for our patients is to experience a pleasant dental environment, while providing the finest care available. We strive to keep our patients families well informed of their dental needs, treatment alternatives, as well as financial options to make your total dental experience as comfortable as possible. This menu is designed to help you better understand our financial policies.

### Payment

Payment is expected the day services are provided. For your convenience Master Card, Visa, debit cards, checks and cash are accepted. As dental needs are diagnosed, a treatment plan will be provided showing these needs, estimated fees and payment due to begin treatment. If a financial concern is anticipated, in which payment in full as arranged cannot be remitted, please inform our office immediately. We offer approved extended payment plans through an outside source.

### Dental Insurance

If you have the benefit of dental insurance, we accept most **Primary Insurance Plans** that do not require a specific provider. Please bring your identification card, signed insurance form and benefit booklet to your first visit. Dental insurance is not intended to be a "pay-all" service, but to help reduce "out of pocket" expenses. We will file Primary Dental Insurance Claims. Please be prepared to pay deductibles and estimated co-payment in full as treatment is initiated. **Please note, we do not accept assignment of benefits for Secondary Insurance.** Therefore, after Primary Insurance responds any remaining balance is due in full. As a courtesy, we will prepare a Secondary Insurance Claim form, submit the claim and request the carrier reimburse the subscriber directly.

### Insurance Payment

As a courtesy, we will file your Primary Insurance Claim and are willing to wait up to 60 days from date of service for the insurance to respond. We will contact your carrier and determine if there is a delay and strive to resolve the situation. If unable to immediately resolve the delay, a statement will be forwarded and payment is due in full by the responsible party. We'll instruct the dental carrier to reimburse the insured Party directly. As a healthcare provider, our relationship is with you, not your insurance company. Our primary concern is for the well-being of your family and will structure our care accordingly. Insurance companies determine benefit packages and payment rates (usual and customary fees-UCR) by the type of plan that is purchased by the employer/insured party, not the level of care the patient needs. All charges are your responsibility from the date services are rendered, regardless of the insurance benefits, arbitrary determination of UCR, or lack thereof.

### Appointments

We see patients on a "by appointment" basis and ask you to call in advance to reserve time for your family. **If you experience a scheduling conflict with a reserved appointment, please contact us as soon as you possibly can.** In instances where appointments are cancelled or failed with one business days notice or less. A minimum fee of \$50.00 may be charged to your account. This fee must be paid prior to your next dental visit. We appreciate your assistance in our scheduling guidelines.

### Returned Check Fee

A fee of \$40.00 or 5% of the balance, whichever is greater will be charged for any returned check. After two returned checks are received, the account will be placed on a "cash only" basis. The outstanding balance and returned check fee must be paid immediately upon notification from our practice and prior to the next scheduled appointment.

### Acknowledgement and Authority

A consent to treatment as necessary or desirable for the patient named, including but not restricted to drugs, medicine, performance of operations & conduct of laboratory, x-ray, or other studies that may be used by the attending Doctor, staff or qualified designate. I authorize Tim Dudley, DDS to release any information to a third party &/or health practitioner. I authorize & request my insurance company to pay Tim Dudley, DDS directly, otherwise payable to me. **I understand my insurance carrier may pay less than the total bill for services & unconditionally agree to be responsible for and to pay all charges incurred on my behalf or my dependants.** In consideration of the services to be provided to the patient, I/we hereby guarantee payment in full of the patient's account in accordance with the financial

arrangements made at the time of discharge or if no such arrangements are made, then payment shall be made in full within fifteen (15) days of discharge. I/we that in the event of default in payment, reasonable collection agency fees, reasonable attorney fees & incidental expenses shall be added to the amount due on the account, plus any applicable court costs. I further understand a 1.5% finance charge per month (18% annually) will be added to my account for any balance over 60 days, regardless of pending insurance claims. I agree to pay Tim Dudley, DDS a minimum fee of \$50.00 for any appointment I schedule and fail to arrive or cancel with less than one business days advance notice. The information I have given today is correct to the best of my knowledge. I also understand this information will be held in confidence and it is my responsibility to inform Tim Dudley, DDS of any changes in my personal or medical status. I authorize Tim Dudley, DDS or qualified designate to perform dental services that I may need during diagnosis and treatment with my informed consent. If the patient is a minor, I certify I am legal guardian and consent to treatment on their behalf.

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

My signature confirms I am legally the Responsible Party, Parent or Authorized Guardian for the patient listed above.