

Promenade Complete Dental Center

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Important Information and Financial Policy

We welcome and value you as part of our dental practice. In order to avoid confusion regarding our financial and insurance policies; please review this document and sign it as acceptance and understanding of what is stated. Our practice accepts cash, check, VISA, MC, Discover, AMEX & Debit cards. If you have any questions, please speak with our office manager.

Today's dental plans are designed to assist patients with dental treatment. It is important to remember that necessary services are not necessarily covered. Our goal as your dental care provider is to make sure you have healthy teeth long after you change dental plans. It is your employer who chooses your benefits and how they are paid by the insurance company.

Please initial the scenario that describes your financial/insurance situation: All outstanding balances are due immediately on the date of service.

_____ I do not have dental insurance. I am responsible to pay my bill in full at each visit. The practice's personnel will give me information on outside financing if I request it.

_____ I understand the practice doctors are participating providers for my dental plan (**Aetna, Cigna and Delta Dental ONLY**). I am required to pay my estimated portion of the dental fee at each visit for the treatment rendered that day. The amount I will be required to pay will be explained to me prior to my appointment. I also understand that my insurance is an agreement between the insurance company and me; therefore, if the practice does not receive payment from my company in 90 days, the insurance balance for my account will be transferred to me personally and needs to be paid promptly, or a 18% interest charge will be added.

_____ I understand the practice doctors are **not** a participating provider for my dental benefit company and they will be waiting for the assignment of benefits as a courtesy to me. I understand that I am responsible for my account regardless of my insurance status. I also understand that my insurance is an agreement between the insurance company and me; therefore, if the practice does not receive payment from my company in 90 days, the insurance balance will be transferred to me personally and needs to be paid promptly, or a 18% interest charge will be added.

I understand that dentistry is not an exact science so my treatment may need to be altered at the time of appointment. I will still need to pay my portion of the visit if different from the original estimate. If the final payment from the insurance carrier is less than the estimated amount, I will assume financial responsibility for the entire not covered balance. The estimated amount due does not take into account insurance deductibles or changes in the payment allowance as delineated by your contract at the time of insurance payment.

All major dental treatment must be paid in full prior to being inserted in your mouth. If I have insurance that the practice accepts, I must pay my portion in full as estimated by the office. I understand that I, the patient, may file with my secondary insurance (if applicable). Also, I am aware that if my insurance denies my dental claim, the office will file an appeal on my behalf. The office will only file one appeal, if there insurance denies the claim again, I will have to file the appeal myself and will be responsible for my balance in the office. I may request information to file an appeal from the office.

I must respect doctors and hygienist's schedule and will give **48 hour notice** if I need to change my appointment time, otherwise I may be charged \$75.00 for the loss of appointment. I also understand that for longer appointments, this charge may be higher.

I give permission for my dentist or his/her associates and clinical team to take any necessary radiographs (x-rays), study casts, and photographs needed to make a complete diagnosis for my dental needs. I also give permission to use this information for in-office educational purposes.

If you want to leave your minor children at the office for treatment without your presence; please read and initial below:

_____ I give my permission to treat my minor child/children in my absence, whether I drop them off for treatment or another adult brings them to the office for treatment. I will give my child a check or credit card information to fulfill the amount due for their treatment.

If you have an adult child (over 18) and will continue to be financially responsible for their treatment please read, fill in child's name, and initial below:

_____ I will continue to be financially responsible for (fill in child's name) _____. If I have insurance, I will provide my insurance company with the necessary documentation that they are a full-time student.

I have read, agreed to, and understand the statements listed above. If I request, I may receive a copy of this document for my records.

Patient Name Printed

Signature (Parent, legal guardian if minor)

____/____/____
Date