



Prestige Patient Treatment and Financial Policy

Patient Name: _____ Date Of Birth _____

Parent Name if Patient a Minor _____

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Office / Financial Policies, which we require that you read, agree to and sign prior to any treatment.

Please Note: Payment is due at the time service are provided. Restorative deposits will be collected at the time appointment is scheduled. Our office accepts cash, personal checks, Master card, Visa, American Express and Care credit. Outside financing is available if needed upon request.

Additional fees will apply for any returned checks. Accounts over 90 days will be subject to Interest being incurred and late fees.

Insurance:

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly what is estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency clauses, age restrictions, deductibles and maximums which are responsibility to know your policy. We are not privy to this information. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. **We only take assignment of payment from your insurance company if we are considered in network to your insurance. Out of network benefits will reimburse you as the Subscriber/Patient.** We will do all we can to help file claims.
- **All charges you incur are your responsibility, Regardless of your insurance coverage and what they pay.** We must emphasize this as your dental care provider; our relationship is with you, our patient, not with your insurance company. Your insurance

policy is a contract between you and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the best course of treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance arbitrary determination of their fees.
- **If for any reason your insurance company refuses to pay their estimated portion all balances are due from you our patient.**
- All deductibles co insurance estimates or co-payments are due in full at time services rendered.
- Insurance payments are usually received within 30 to 90 days if for any reason we do not receive payment in this amount of time and we have resent claims several times , the monies/balance on account will be due from the patient. We will send you a statement with the claim closed to collect the balance owed to the office. Again services are rendered to the patient and not the insurance company. At this point it will become the patient's responsibility to collect what they feel the insurance company should have paid.
- Our office will not, however, enter into a dispute with your insurance company over any claim. This is the patient's responsibility.

Missed Appointments:

Our goal is to provide treatment in a timely manner with as few visits as possible. In order to provide the best services to our patients, we require a minimum of 24 hours notice of change of appointments or cancellations. We understand that unforeseen circumstances may arise which will result in the need to change your appointment. **A fee for missed or broken appointments or appointments cancelled less than 24 hours notice will be charged accordingly. \$50.00 Dollars for every Hour scheduled with the hygienist and 100.00 for every hour of time scheduled with the doctor.** This will be determined on a case by case basis. If a patient has a history of continually cancelling or missed appointments, it may be required for a deposit to be charged at the time the patient schedule's their future appointments.

Minors accompanied by the parent or legal guardian:

The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for the full payment at the time services are rendered, regardless of what the divorce or support papers may read. We are not a party to the legality of the divorce or separation.

Unaccompanied Minors:

The parent or legal guardian is responsible for payment in full at the time services are rendered. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment time.

Restorative Case Deposit Required:

When scheduling restorative appointments such as, crowns, Bridges, Dentures, Extractions, Oral Surgery, Implants, and Partial dentures etc., we will collect 1/3 of the estimated treatment cost. This is required at the time the appointment is scheduled.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay dental benefits directly to my dental office on my behalf. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Communications with you:

By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees charged that you may incur for an incoming call from us, and /or outgoing calls to us, to or from any such number, without reimbursement from us. We or our agents may call by telephone regarding your account. You agree that we may place such calls using automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patient Name Printed: _____

Signature of Patient/Parent /Legal Guardian: _____

Date Signed: _____