Rancho DENTAL PRACTICE

Family Orthodontics & Cosmetic Dentistry

FINANCIAL AGREEMENT

Thank you for choosing us to provide for your dental care. We consider it an honor to have been chosen by you. Our philosophy is to be informative, honest and forthright. Nowhere is that more important than in the area of finances. This Financial Agreement allows you to become aware of your right to know our expectations are in the area of finances. If you have any questions or concerns about our Financial Agreement please ask one of our friendly office staff.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you and not your insurance company.
- You are responsible for our fees and not what your insurance company allows or consider "usual, customary and reasonable" all of which vary from one company to another.
- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely YOUR responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- Your insurance's explanation of benefits is not a guarantee of payment, and is subject to change according to your eligibility at the time of your visit. We depend on your insurance to give us a correct explanation, but benefits can be different for the subscriber and dependents.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non-covered services, along with deductibles and copayments are due at the time of treatment.

PAYMENT POLICY

- We accept cash, personal checks, debit cards, Visa, MasterCard, American Express, and Discover.
- After dental insurance has paid its portion, a statement will be sent to the mailing address on file for the remaining balance or charge the credit card on record. Payment is expected within 25 days of the statement date, to avoid finance charges. It is then your responsibility to contact your insurance regarding your balance.
- If the insurance company does not pay in full within 45 days, it will be your responsibility to pay the remaining balance within two weeks. Your help in seeing that your claim is paid within the 45 days is appreciated.
- We do not file claims for medical insurance or more than one dental insurance company per patient.
- Our office has a fee for service policy, requiring all fee (minus insurance's estimated portion) to be paid at the time of treatment.

PATIENTS WITHOUT INSURANCE COVERAGE: We provide written estimate of fees, and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without

any exception. This office will not attempt to collect payment from a parent that is not present in the office at that visit.

RETURNED CHECKS: A $35.00 charge applies when a check is returned by the bank.

FINANCE CHARGES AND COLLECTION FEES: Finance charges will be applied to all balances not paid within 25 days of the monthly billing date. A late charge of $25 will be applied to your account for each month that the balance is not paid. A charge of $30 will be placed in your account if the credit card provided is declined. It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

OVER DUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt: an interest rate of 21% on the unpaid balance from the last date of service, attorney fees, court fees and any other fees associated with the collection of your debt.

BROKEN OR MISSED APPOINTMENTS: Appointments not kept or changed with less than 48 hours notice are considered broken. Broken appointments include canceling or rescheduling an appointment with less than 48 hours notice and failed appointments. Broken appointments prevent others from receiving the dental care they deserve. We take them seriously so please be considerate and inform us in advance if you need to change your appointment.

FEE FOR MISSED APPOINTMENT IF 48-HOUR NOTICE NOT GIVEN: To reschedule or cancel an appointment, you must notify us at least forty-eight (48) hours in advance to avoid a missed appointment fee of up to $50. We reserve the right to terminate professional treatment of any patient when scheduled appointments are not kept.

RECORDS AND REIMBURSEMENTS: Original records including radiographs are the property of this office. If you desire we will provide you with a copy of your record or radiographs upon written request. Please give our office a minimum of 2 business days notice to process your request.

CONSENT & AUTHORIZATION: I authorize dental treatment on myself and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Rancho Dental Practice. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Name_____ Signature_____

Relationship to patient _____

Date_____

Are you the person legally responsible for this child/dependent? Yes _____ No _____

Reviewed by staff member _____ Date _____