OFFICE POLICIES

FINANCIAL POLICY

Payment Options:

We accept Cash, Check, Visa, Mastercard, Discover, or American Express

We also offer attractive Financing options from Care Credit (Subject to credit approval):

- Convenient monthly payments to help make treatment affordable.
- No interest financing available up to 12 months.
- No annual fees or pre-payment penalties.

For patients without dental insurance, we offer a courtesy adjustment of 5% when you pay with cash or check at the time of service. We also offer an additional 5% courtesy adjustment for any treatment paid in advance.

Payment Requirements:

- We require payment in full at the time of treatment, unless prior arrangements have been made.
- For appointments with treatment costs over $1000.00, we require 50% due at scheduling and the remaining balance to be paid upon completion of treatment.
- For treatment plans requiring multiple appointments, the total balance due may be divided into equal payments to be made at the time of each appointment.

Insurance Information:

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and we will bill your carrier directly to collect reimbursement for your treatment. Be advised that any amounts proposed to be paid by insurance providers are estimates only, and that no guarantee can be made by our office regarding these amounts. In the event that the amount paid by your carrier differs from the estimate, you may be billed for the outstanding balance. Any financial balance is ultimately your responsibility, and you may be billed for any claim not paid by your insurance provider within 60 days.

We will always make treatment recommendations based on individual needs and with regards to optimal oral health for our patients. It is our goal to provide our patients with the level of care that they desire and deserve, and we will not allow insurance plans to dictate the level of care we offer to our patients. We maintain that insurance is a method of payment, and not a method of treatment.

PLEASE INITIAL_____

APPOINTMENT POLICY

Your appointment times are very important. Several staff members are employed to ensure that visits to our office are mutually time and cost effective for our patients and our practice. In order to maintain the integrity of our schedule, we must hold strictly to the following standards:

- We require 24 hours notice for any cancellation, or rescheduling of your appointment.
- Failure to provide 24 hours notice on any missed appointment will be subject to a **fee of $50 per hour missed**.

PLEASE INITIAL_____

ASSIGNMENT OF BENEFITS

I authorize payment of my dental benefits to be made directly to CrossPointe Dental.

PLEASE INITIAL_____

I have had the opportunity to review the **Notice of Privacy Practices** policy: **PLEASE INITIAL_____**

(Laminated form on clipboard)

I understand and agree to the office policies explained above:

Name (Please Print)_____ Signature:_____ Date:_____

FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A monthly service charge at a fixed rate of 1.5% per month/18% per annum* of the unpaid balance as of the last day of each month will be assessed and added to the balance on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional services to be rendered to me, (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency to whom a delinquent account is assigned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier, another oral health provider/specialist or any related entities that require such information to be submitted.

I acknowledge that I have reviewed a copy of this office's Privacy Policies, that I have been given the opportunity to ask questions about the policy, and that a copy will be provided to me upon my request. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

Signature of Patient or Authorized Agent: _____

Print Name: _____ **Date:** _____