Salem Creek

Financial Policy

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 can obtain optimum oral health. The following is statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express. Outside financing is available upon request and approval.

Do you have insurance?

- As a courtesy we will fill your insurance claims for you. **Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated.** Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make your estimate as accurate as possible.
- I understand and agree that I am ultimately responsible for all fees incurred for my dental treatment regardless of payment or denial of my insurance claims. We must emphasize that your individual insurance policy is a contract between you, your employer, and you insurance company, and our office is not part of that contract.
- **Our office is committed to providing the best treatment for our patients and we charge what is usual and customary for out area.** You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- I authorize the release of information to insurance company, attorney or legal representative to obtain reimbursement of any claim(s) or for other reasons (worker's comp, accident, etc.)
- **We ask that you pay the deductible and co-payment**, which is the estimated amount not covered by insurance company, by cash, check, MasterCard, Visa, Discover, or American express **at the time we provide the service to you**.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount. We will, however, continue to work with you and your insurance company to expedite your reimbursement.
- We will cooperate fully with the regulations and requests of your insurance company to assist with the claim to being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- When being referred to a specialist, I am responsible for making sure that the doctor is on my insurance plan.
- A fee of $35 will be incurred for each returned check. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal chares up to 35%.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE: I, the undersigned, give Salem Creek Family Dental, its employees and/or agents "express Prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone or text message) or email, for the purpose of treatment, insurance and/ or payment, and messages may be left on any answering services at such given numbers.

CONSENT:

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, collection charge, and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at the number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

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Patient Signature (Guardian) Date