

Summit View Periodontics Office Financial Policy

We welcome you to our office. We are committed to your treatment being successful. Please understand that payment of your bill is part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

_____ Payment is expected as services are rendered. If you are covered by dental insurance, we expect payment for deductibles and co-payments on the date of service. For your convenience we accept **cash, check, Visa, MasterCard, Discover** and **Wells Fargo Health Advantage (ask for details)**.

Regarding Insurance

_____ We are happy to extend the courtesy of billing your insurance company for you. However, in order to provide this service to you, we must have **COMPLETE** insurance information and confirmation of your coverage. It is your responsibility to fill out the necessary forms that give us all the insurance information required. If this information is not provided to us in a timely manner, we will be unable to bill your insurance company for you and you will be expected to pay in full for services rendered. If we have not received payment from your insurance company within 60 days of billing, the balance is due and payable by you, the patient. Your insurance is a contract between you and your insurance company and we are not a party to that contract. We try our best to provide you with the best estimate possible based on the information we receive from your insurance company. With that explained, it is only an **ESTIMATE**. You will be expected to contact them directly if a problem should arise. Remember that we treat you as the patient, not your insurance company. We expect all balances to be cleared in less than 90 days. Pre-authorizations can be requested by you, the patient. Please keep in mind that this will delay treatment until that information is processed by your insurance company. This process can take 4-12 weeks depending on the insurance company. Please keep in mind that a pre-authorization for treatment received by your insurance company is still not a guarantee of benefits.

Usual and Customary Rates

_____ Our practice is committed to providing the best treatment and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please keep in mind that we can only **ESTIMATE** what your insurance will pay since each insurance company has their specific limitation and exclusions that are not determined until the final claim is received and processed.

Billing

_____ For all accounts over 60 days with patient amounts due, there will be a finance charge of 1.5% per month.

_____ All insufficient funds transactions will be subject to a \$35.00 returned fee.

_____ Should the situation arise, accounts over 90 days may be assigned to a collection service for processing. At that time you agree to pay any reasonable additional fees, including any and all collection agency, legal fees and/or court costs, necessary to collect this account.

Missed Appointments/Cancellation of Appointments

_____ We understand that emergencies do arise. However, because we reserve specific times for you and your treatment, a 48 business hour notice (Tuesday through Friday) for ALL appointments is required. Otherwise a charge of \$100 per hour will be made to your account. Rescheduling of a surgical appointment will require a \$250.00 non-refundable deposit. While we try our best to confirm your appointments by phone or text, this is a courtesy and we ask that you not rely on this. It is the patient's responsibility to know their appointment times. Please note that cancelations/changes in appointments are not accepted over voicemail, text or email.

I have read and agree to this financial policy.

Patient or Parent/Legal Guardian Signature

Date