EAST TOWNE
DENTAL ASSOCIATES

FINANCIAL POLICY

Taking care of you and your family is our top priority. However, when talking about finances, we need to avoid any chance of misunderstanding by being clear with all fees, financial options, and how you have chosen to handle your financial responsibilities. The result of this form is a financial agreement that we ask you to sign and an official representative to sign so that we can both count on clarity in this important matter.

At the onset of your treatment, we will provide you with an estimate of the total fees expected. Please note that this is an estimate only. Treatment may change for a variety of unforeseen reasons. When estimating insurance payments or coverage, we must also stress the word estimate, as insurance companies continue to surprise us at times. If the insurance company pays more than expected, you will receive a refund. If they pay less than expected or deny the expected benefit, you will receive a balance due on your statement. If your insurance denies your eligibility after the fact, the balance becomes your responsibility. We request the balance due within 30 days of the receipt of your statement. You can request a pre-authorization before beginning the treatment.

PAYMENT OPTIONS

☐ PLAN A: MONTHLY PAYMENT PLANS

For our patients who want to make monthly payments, we offer short- and long-term financing through CareCredit and Lending Club Financing. A member of our business office team will gladly assist you with the application process.

☐PLAN B: INSURANCE COVERAGE

Our goal is to do whatever it takes to help you maximize your insurance benefits, and as a courtesy, we are happy to bill your dental insurance for services. Please remember that the contract for your insurance coverage is between you, your employer, and your insurance carrier, and your estimated portion is due in full the day of treatment, or you may choose Plan B for your estimated patient portion.

☐PLAN C: SELF PAY

We accept cash, check*, Debit Card, Discover, Master Card or Visa

INITIAL BELOW

_____ I understand that a $35 service fee will be added for any checks returned for any reason and I will be responsible for payment of this fee and the amount of the returned check. Non-sufficient fund checks must be redeemed with certified funds (cashier's check, money order or cash)

_____ I understand that I have until two business days before my appointment to cancel or reschedule. If I do not show-up for my appointment or cancelled late, a $50 per hour (scheduled appointment time) late cancellation or no-show fee may be charged to my account.

_____ I have chosen the above option and accept full financial responsibility for this account. I understand that any insurance estimate given to me by this office is not a guarantee of actual insurance payment or coverage. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon my dependents in this dental office. Any insurance claim not paid in full after 60 days from the date of service will become my responsibility to pay at that time

Name of Dependents: _____

_____

_____ _____

Patient/Guardian Signature Date

_____ _____

Financial Coordinator Signature Date