Dicus Family Dentistry

Financial Policy

Welcome!

Thank you for entrusting us with your oral health care. In order to enhance communication and promote understanding regarding this office's financial policies, please read over the following information. **By providing your signature, this indicates that you have read, fully understand, and fully agree to our policies.**

Insurance: Our office is committed to helping you maximize your insurance policy and we will gladly file your claim with any insurance plan. I authorize Michael T. Dicus, DMD and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal on my behalf. Because insurance policies vary greatly, **we can only ESTIMATE your coverage** in good faith and cannot guarantee coverage due to the complexities of insurance contracts. As our fees may exceed that which your insurance company covers for our services, your estimated portion must be paid at the time of service. **If your insurance company pays less than the estimate, or if for any reason denies or downgrades coverage to an *alternative benefit* on the claim, you are still responsible for paying the remaining balance or making financial arrangements at that time.** Every effort will be made to secure payment on your behalf. Additional funds from insurance will be refunded or a credit to your account will be issued. It is not possible for our office to file medical insurance. Additionally, if we are contracted with your insurance, these contracts prohibit us from offering discounts off of your patient portion. Please see our "Thoughts on Insurance" handout for FAQ's. **Initials _____**

Patient Payment: We accept cash, Master Card, Visa, American Express, Discover Card, and local checks. We also accept Care Credit. Through this partnership we can offer convenient monthly payment options, no up-front costs, no prepayment penalties and no annual fees. **Initials_____**

Billing: Statements will be sent out when a balance is realized. All patient accounts without payment arrangements are due in full within 30 days. *After the third billing cycle (90) days in which payment on your account is not arranged, it will be turned over to our collection agency. In addition to the amount owed, you will also be responsible for any collection and/or legal fees associated with collecting the balance due.* A service charge of 1½ percent per month (18% per annum) will be charged on all accounts exceeding 60 days, unless previously written financial agreements are satisfied. **Initials _____**

Returned Check Fee: A $50 returned check fee will be assessed for all returned checks, and no future checks will be received as payment. **Initials _____**

Broken Appointments: A specific amount of time is reserved **just for you** with your doctor or hygienist. If you must change your appointment, we require at least 48 hours' notice to avoid a $25 per half- hour cancellation fee that may be assessed to your account. Multiple missed appointments will subject your account to same day only scheduling and/or deposit required to schedule. **Initials _____**

We welcome you to our family and look forward to helping you establish and maintain a healthy, beautiful smile. If there is anything we can do to make your visit here more pleasant, please don't hesitate to ask one of our team members.

Name: _____ Date: _____

Signature: _____