DESERT FAMILY DENTAL FINANCIAL POLICY

We appreciate your selection of this office to serve your dental needs. Our interest is to provide our patients the finest possible, quality dental care. We must attend to the financial aspect of dental treatment as well. Following is an overview of our office financial policy.

Payment. Payment in full is required at the time of service. For your convenience, we accept cash, debit, and credit cards, including Visa, Mastercard and Discover. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit.

Insurance. Dental Insurance never pays for 100% of all dental services. As a courtesy, we will bill your dental insurance for your care, providing you give us **ALL** the necessary information for claim submission.

- At the time of service, we will request from you an initial payment, the ***estimated*** portion of the charges which insurance may not cover, including all applicable deductibles and co-pays.
- After your dental insurance settles your claim, any remaining balance is your responsibility.
- Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) day grace period from the date of service, the remaining balance in full is your responsibility.
- Questions and concerns with your dental coverage and the payment of your claim(s) are the sole responsibility of the insured, and should be resolved with the insured's employer and the dental insurance company, and our office has no control over payment or non-payment of your claims.
- As your dental care provider, we advise treatment that is in the best interest of your medical and dental health. Insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs.
- It is the sole responsibility of you, the patient, to familiarize yourself with the rules, terms, exclusions, clauses, and benefits limitations of your dental insurance policy.
- We will submit to a total of two insurance plans per patient. If you have more than two dental plans it will be your responsibility to file any additional claims.
- Occasionally, certain procedures may fall under your medical coverage. We do not bill you medical insurance and it will be your responsibility to know you plan and file any medical claims for reimbursement.
- Health Saving Plan/ Flexible Spending Plans – You as the patient are fully responsible to communication with your plan. We will provide a detailed receipt for your convenience.

Estimates. Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed upon your approval.

Aged Account. The total balance on your account after claim settlement is due immediately upon receipt of statement. Failure to keep this account current may result in DESERT FAMILY DENTAL being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees, finance charges, collection agency fees, attorney's fees and court costs.

Copyright. Any comment posted online in any way relating to DESERT FAMILY DENTAL or any Employee, will be sole right and property of DESERT FAMILY DENTAL and the copyright of the content of the comment, ratings, or review is herby assigned to DESERT FAMILY DENTAL to utilize or delete at our discretion, and/or in order to protect the patient's anonymity and privacy.

Appointments. If unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. ***Notice of less than 48 hours will result in a minimum charge of $50.00; the amount may vary depending on the magnitude of the failed appointment.***

Assignment of Benefit. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Desert Family Dental.

I have read, understand and agree to the above.

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Signature of Person Responsible for Account **Printed Name of Person Responsible for Account** **Date**