FINANCIAL POLICY

Please understand that **PAYMENT OF YOUR BILL IS CONSIDERED PART OF YOUR DENTAL TREATMENT**. Our experience has shown that patients appreciate knowing what their financial responsibilities are before treatment begins. Knowing ahead of time allows you to make arrangements to meet your obligations without being surprised at the end of treatment. Please read & sign this form indicating your understanding of, and agreement to, these terms.

WE ACCEPT: Cash, personal checks, major credit cards, or "Care Credit", a company which offers 6, 12, or 18 month no-interest payment plans and/or low-interest, long-term financing. Please ask for details.

MISSED APPOINTMENTS: Please help us serve all of our patients better by keeping your scheduled appointments. We reserve the right to charge a $50 fee for appointments not cancelled at least 24 hours in advance.

USUAL & CUSTOMARY FEES: Our fees are based on average fees for our area. We participate in an annual fee survey of dentists who practice in the northern Utah area, and find, almost without exception, that our fees are at or below average.

Most dentists have found that insurance companies tell their subscribers that some dental fees are "above the usual and customary (UCR) fees", rather than telling you that the benefits they provide are too low. Some insurance companies do not upgrade their fees often enough, even though the cost of living rises. You are responsible for payment regardless of an insurance company's arbitrary determination of what constitutes "usual & customary" fees.

INSURANCE: We accept assignment of your benefits, which means that the insurance carrier will send payment of their portion of the charges directly to our office. We will prepare the claim forms and assume the cost of mailing them to the insurance carrier. HOWEVER, please understand that your insurance policy is a contract between your employer, or you, and the insurance company. We are not a party to that contract. ***You are responsible for all charges which insurance does not cover.*** The estimated amount of your portion will be explained to you before treatment begins.
No insurance company pays 100% of all fees.

Some services provided may NOT be covered by your insurance policy. Since we deal with many insurance companies, and an even greater number of differing policies offered by these companies, we cannot be responsible for knowing all provisions of all policies. Some policies pay a "fixed amount" per procedure (co-pay); while others pay a "percentage" of the procedure fee (co-insurance). It is your responsibility to understand your policy's deductibles, co-pay and co-insurance amounts, annual maximum benefit amount, as well as the policy's limitations and exclusions.

SECONDARY INSURANCE: Having more than one insurance DOES NOT necessarily mean that dental work will be covered 100%. Secondary insurance pays based on what the primary insurance paid. Some secondary policies have a "non-duplication" clause when coordinating benefits which limits their liability. Please be familiar with your policy's provisions.

CO-PAY / CO-INSURANCE: **Co-pay and co-insurance amounts are due at the time of service, unless previous arrangements have been made.** We will estimate these amounts as closely as possible. If your insurance company pays less than we estimated, we will send you a statement after we receive their payment. "Co-pay" is a fixed dollar amount paid per procedure or visit (such as a regular check-up). "Co-insurance" is the percentage of the charges for basic and major procedures which your policy requires that you pay: for example, 50% on crowns, or 80% on fillings, etc.

MINOR PATIENTS: The adult accompanying a minor child and/or the parent/guardian of the minor child are responsible for full payment regardless of divorce or separation issues. These issues involve the parents, NOT our office.

FINANCE CHARGES AND Interest will be charged at 1-1/2% per month (18% annually) on balances over 60 days, with minimum charge of $1.00.

If it becomes necessary to refer this account to a collection agency, **a fee of 45%** of the principal balance owing will be added to the amount to be collected. **I agree to pay all collection costs and reasonable attorney fees if a suit is filed to collect money owed by me.**

RELEASE OF INFORMATION: I authorize release of financial information concerning my account, including charges, payments, and interest assessed to the dentist's collection agency or collection attorney if any collection procedures described above become necessary.

PLEASE LET US KNOW IF YOU HAVE QUESTIONS OR CONCERNS AND WE WILL DO OUR BEST TO ADDRESS THEM.

I HAVE READ THE FINANCIAL POLICY ABOVE. I UNDERSTAND AND AGREE TO ABIDE BY THIS POLICY.

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Signature of patient or responsible party **Date**