Insurance & Financial Considerations

We care about you (our patient) and we know that having surgery can cause anxiety (to say the least). We do not want the financial aspect to add any confusion, so we have provided this information to help you understand clearly your payment options and responsibilities.

An estimate will be provided prior to your treatment**.**

IT IS ONLY AN ESTIMATE. WE HAVE NO WAY TO DETERMINE YOUR FINAL PAYMENT. ***All estimates are based on primary dental insurance only.***

Your estimated down payment is due on the day of your procedure.

After insurance billing is complete, you will be billed any further balance due or you will be refunded any overage. We make every effort to ensure your refund is received. If for any reason you do not receive it, signing indicates you want it to remain on your account for further treatment or refund.

We will submit 2 insurance claims for you at no charge. Any additional submissions, resubmissions or request for additional information will carry a minimal fee to you at the rate of $15.00 for each occurrence.

Any balance remaining on your claim is due in full 90 days after services regardless of whether or not your insurance has made payment. We will work with you and your carrier to try and finalize payment before this time.

Insurance is a contract between you and your insurance company. We may NOT be a party of this contract. Although we may ***ESTIMATE*** what your insurance company may pay, **it is the insurance company that makes the final determination of your eligibility and financial responsibility.**

It is **your** (patient) responsibility to determine your insurance eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company. Our policy is to assist our patients in determining their insurance benefits. We do not always determine and may not even have knowledge as to whether any particular insurance is designating us as a provider. **It is the patient's sole responsibility to contact their insurance provider prior to being seen to determine our network participation in your plan.** Treatment at our office is the sole responsibility of the treated individual or guardian unless the insurance contributes to the cost of treatment.

Any account not paid in full by 90 days will be assessed a 5% per month Account service charge.

Returned checks: A fee of $35.00 is charged if a check is returned by the bank for any reason and the account is then to be paid in full immediately by cash or money-order.

Past Due Accounts: On any past due account you agree to pay any collection, attorney or court cost incurred. In case of any legal action you agree the venue shall be in Butler County. Ohio Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency. The fact that you received treatment at our office may become a matter of public record.

I have read, understand and agree to all preceding financial terms and conditions.

Name: _____ Date_____