Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is necessary in order for us to provide treatment.

Patients with Dental Insurance

As a courtesy to our patients, we prepare and process all insurance forms. However, having insurance does not release the patient from responsibility.

Our expectations of you as the owner of the policy are as follows:

1. Estimated patient portions must be paid at the time of service. This may include co-payments, deductibles, co-insurance and/or non-covered procedures.
2. You are responsible for educating yourself about the details of your policy which includes deductibles, yearly maximums, and policy exclusions.
3. If the insurance company does not pay our office **within 60 days**, it is your responsibility to pay using one of the payment methods listed below. The insurance policy belongs to you and we have no leverage to obtain payment.

A finance charge of 1.5% per month (annual percentage rate **18%**) will be assessed on any unpaid balance over 60 (sixty) days regardless of insurance estimates. Insurance estimates are based on limited information provided to our office by your insurance company and is not a guarantee of coverage or payment.

Please initial _____

Patients without Dental Insurance

If there is no insurance coverage, full payment is due at the time of service with one of the payment methods listed below.

Payment Options

For your convenience, you may choose any of the following **methods of payment:**

- Cash
- Personal Check (postdated in necessary)
- Visa, MasterCard, Discover, American Express - Credit or Debit
- Extended Payment Plan with one of our Financing Partners, Citi Card or Wells Fargo
  Short-term plans are available with no interest. Credit approval must be received PRIOR to treatment

Broken & Missed Appointments

Please make every attempt to keep your scheduled appointments. If you must cancel or reschedule, kindly notify us at least 48 hours in advance. **There is a $36 charge for all appointments that are broken or missed** without a 48 hour notice.

Please initial _____

X-ray Copies

The law requires us to keep all x-rays that are taken in our office, however, you may request copies. There will be a charge for copies.

Minor Patients

The parent, guardian or adult accompanying and signing all forms for a minor will be responsible for full payment. Parents or guardians must be present to authorize all dental treatment to minors.

Financial Agreement

I understand that I am financially responsible for all charges incurred by my dependents, or myself whether or not covered by insurance. I hereby authorize the office of Perry Dental Associates to use the following signature for proof of signature on insurance claim forms for assignment of insurance payment and release of information. I agree to pay Perry Dental Associates professional services rendered to me at the time of service. If my insurance pays less than estimated, I agree to pay any remaining balance within 30 (thirty) days of billing. I expressly agree to pay all costs of collection agency fees assessed at 47% of the total amount due, and all court costs and attorney fees, if these terms are not met.

_____	_____	_____
Signature of Patient or Responsible Party	Print Name	Date