Periodontal Associates Financial Policy

Thank you for selecting our office for your periodontal treatment. Our objective is to provide you with outstanding dental care. For this reason, we want to provide you a thorough understanding of our financial policy.

The fee for your treatment is based upon your treatment plan. We will review the fees associated with your treatment plan after the doctor has performed a thorough evaluation of your case. **PAYMENT IS DUE FOR ALL SERVICES RENDERED ON THE DATE OF SERVICE.**

You shall be directly responsible for all payments for treatment, regardless of insurance coverages. The office shall make all reasonable attempts to assist with insurance coverages but the ultimate responsibility for payment remains with the patient or legal guardian.

By signing and acknowledging this form, you agree to the following:

I accept financial responsibility for any/all procedures performed by the practice, its doctors and staff.

I accept responsibility for payment for all treatment provided to me regardless of insurance coverage.

I accept responsibility for treatment for minors or and adult for which I am the parent and/or legal guardian.

I hereby provide consent and approval for the office to charge me for reimbursement of any credit card and/or merchant processor fees and expenses incurred by the office and/or its business support provider in allowing payment by credit card.

PLEASE NOTE WE PROVIDE CONVENIENT THIRD -PARTY FINANCING OPTIONS WHICH WE CAN PROVIDE UPON REQUEST.

Name and date: _____

DENTAL INSURANCE COVEREAGE

If you have dental insurance coverage, please provide all dental insurance information prior to service and our office will assist you with filing your insurance claim. Please understand that we will provide an insurance ESTIMATE to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid.

It is important to recognize that once we file your insurance claim, we are not responsible for claims that are denied for any reason. The patient is responsible for any balance due if a claim is denied. Please keep in mind that this is only an estimate and coverage verification does not guarantee payment. It also does not guarantee the estimated cost given to you is the total amount due. You agree to pay the BALANCE not paid by your insurance company.

CREDIT CARD ON FILE

In an effort to minimize cost, we request patients leave a debit/credit card on file for any credit or remaining balance on your account after the insurance company makes a payment.

FOR USE OF A CREDIT CARD, YOU WILL BE RESPOSIBLE FOR REIMBURSMENT OF APPLICABLE CREDIT CARD FEES AND EXPENSES AS INCURRED BY THE PRACTICE. SUCH ADDITIONAL CHARGES AND EXPENSES WILL BE INCLUDED IN YOUR INVOICE.

DEPOSITS:

Surgical cases will require a deposit of 1/3 of the patient portion due at the time of scheduling. This deposit is nonrefundable if the appointment is short cancelled or no show.

NO SHOW OR CANCELLATION:

If a patient cancels less than 24 hours or no shows for their appointment the patient will be charged 50.00 for a cleaning, 75.00 for a deep cleaning and 150.00 for a surgical appointment.

RETURN CHECK POLICY:

There will be a $50 dollar charge for any checks returned for insufficient funds. We also reserve the right to refuse this form of payment in the future.

We reserve the right to send any account to collections that is over 90 days arrears.

If you have any questions regarding our office policies or fees, please do not hesitate to contact us prior to your visit or speak with our office manager prior to treatment.

REFUND POLICY:

ALL refunds will be issued in the original form of payment. Once approved, refunds may take at least 7 Calander days to process.

PATIENT:

Name:

Date: