Dental Art Designs
Juana Geldres, DDS, PA.

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Patient Name: _____ Date: _____

FINANCIAL POLICY

It is the policy of this office to help keep your dental health care cost as low as possible. In order to do this, we need to keep our billing cost to a minimum. Please help us in the following ways:

- Always bring your current dental insurance card to the office
- Please notify us at the time of check-in of any changes in insurance, address, phone numbers, etc.
- Please double check your insurance plans as to the participating status of the office. We will not deny care to any patient due to the uncertainty of participation status of the office with your insurance company. Please understand that you are responsible for verifying this information with your insurance.
- If we are not able to verify your insurance at the time that services are rendered we will not deny care, but please understand that you are responsible for the charges that will incur and payments are expected in cash, credit card or Care Credit on the same day the services are rendered unless other arrangements are approved prior to the visit.

We only accept the following as methods of payment

Cash Care Credit Discover MasterCard Visa American Express

NO CHECKS

PAYMENT OPTIONS

Your dental health and smile are important to us. Therefore, we have contracted with many insurances and have payment programs designed to help you.

1. We accept most insurances. We are required by our insurance contract to collect co-pays and/or deductibles at the time services are rendered. Co-pays not paid on the day of the visit will be subject to a $20.00 co-pay processing fee. It is the responsibility of the card holder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the card holder verify coverage limits prior to their appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance.
2. If you have no insurance, we offer great discounts and promotions that are sure to satisfy your dental needs. In many cases when payment in full can't be made, we can offer an individualized budget agreement. If your bill is paid in full by cash, other discounts may apply.
3. Care Credit is accepted here and we can also help you with the application process. This can help you with the co-payments, deductibles and treatments not covered by your insurance. It can also help you with unexpected dental emergencies and enable you to start treatment immediately. This is good both for insured and not insured patients.

MONTHLY STATEMENTS

If you have a balance on your account, a statement will be sent to you. The balance on the statement is due and payable when statement is issued and will be considered past due in not paid within 15 days. If the account becomes past due, we will take the necessary steps to collect this debt. All accounts sent to the collection agency will be reported to the Credit Bureau and you agree to pay all the collection fees and processing fees that may apply. **There is a fee** for all credit card transactions that are charged back of $45.00 and other fees may apply. If you have concerns or questions, please feel free to discuss them with the doctor or proper staff member to help you.

TRANSFER RECORDS

You will need to personally complete the authorization of records release form. All balances have to be paid before any records are obtained or transferred. There is a charge from $15-$25 for all copies with x-rays and a 48hr notice needs to be given to the office after you have no outstanding balances in the office, this includes, but not limited to, treatment, dental supplies, insurance portions and copy fees.

MISSED APPOINTMENT FEES

You will need to pay a fee for any appointment missed, changed or cancelled without a 24hr notice. **The fees are as follows**:

1. General Dentist: $30 per half hr. / $60 per hr.
2. Hygienist: $30 per half hr. / $60 per hr.
3. Orthodontic TX: $30 per appointment
4. Scaling & Root Planning: $75 per visit
5. Periomaintenance: $50 per visit

Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.

Initials: _____

After reading and understanding, I request that services to be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make a payment when due and my account becomes delinquent it will be turned over to a collection agency. I am fully responsible to pay all collections costs and processing fees that may apply. I will also be at risk to be dismissed from the practice as a patient.

I have read this Financial Policy as outlined **above** and understand that I am ultimately responsible for the charges incurred by my child/children as their legal guardian.

Signature: _____ **Guardian/Parent Name (if minor)**:_____

Guardian/Parent Signature _____