

**FINANCIAL POLICY**

* With the daily changes that are made with insurance, your carriers have made it impossible for us to accept the responsibility of knowing your plan’s provisions, e.g., benefits, payments, coverage, waiting periods and whom you can or cannot see. **Knowledge of your insurance coverage is your responsibility**.
* We will attempt verify your dental insurance and provide you with an estimated cost of care; however, your insurance company only provides our office limited information. This is only an estimate as the final amount is unknown until payment is received from the insurance company. We would be happy to file a pre-determination with your insurance company prior to treatment. However, this will delay your treatment and the pre-determination is not a guarantee of coverage or payment.
* Although your insurance may assist you with partial payment of your healthcare, a 25% down payment of the estimated patient portion is due to reserve your treatment appointment. If the estimated patient portion is under $100.00, the full amount is due in order to reserve your appointment.
* We accept the following payment options:

Cash Check CareCredit Mastercard

 All Major Credit Cards

* If you request a pre-determination on the same treatment multiple times, a $50 fee will be charged for the second and subsequent pre-determinations. Once you opt for treatment for the services on the pre-determinations, the $50 will be applied toward the patient portion of the service.
* We may file medical insurance for some dentistry procedures as a courtesy whenever possible.  We cannot guarantee payment through your medical insurance and you will still be responsible for the fee should the medical insurance deny payment.
* I authorize all insurance benefits to be paid directly to Dr Will Jones.
* If payment by the insurance company is made to the insured, I agree to endorse or have the insured endorse the benefit check to Dr Will Jones, or make payment immediately to Dr Will Jones.
* Once the insurance company has rendered payment for services, any unpaid balance is due upon receipt.
* I authorize this office to discuss my account with a spouse, parent/stepparent, or person assuming payment for the account.
* There will be 1.5% interest charged monthly on any unpaid balance over 60 days.
* A $40 charge will be added for any returned checks.
* If the account is turned over for collections, I understand that I will be responsible for any collection fees, attorney fees, processing fees and court fees.

I have read, understand and agree to the above financial policy.

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Patient/Guarantor Signature Date