Clermont Family Dentistry

Financial Policy

We are privileged you have chosen us as your dental care provider. We are committed to providing you and your family with quality patient care. The following is a statement of our Financial Policy, which you need to understand prior to treatment. If you have any questions, please feel free to ask.

Full payment is due at the time of service. Any outstanding balances are due prior to additional services. We accept cash, checks, and most major credit cards.). I understand that if I pay by check and the check is returned, **there will be a $25.00 fee.**

I understand that because appointments are not double-booked, I must provide notice of cancellation with 2-business days prior to my scheduled appointment time. ***For appointments scheduled for 90 minutes or longer, I will be required to make a reservation fee of $50 prior to scheduling the appointment, which will be applied to my out-of-pocket expense for the appointment. This reservation fee is non-refundable. If I do not show up for my appointment or I do not give adequate notice if I am unable to keep my appointment, the reservation fee will be forfeited. For appointments scheduled for less than 90 minutes, a Open Chair Fee of $50 will apply if I do not provide notice of cancellation with 2-business days prior to my scheduled appointment time.***

Please note: *If your appointment is not confirmed by noon the day prior to your scheduled visit, your appointment* ***WILL*** *be removed from the schedule and an Open Chair Fee will apply.*

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay. However, as a courtesy to our patients, we will file your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and copayments as accurately as possible. Please understand that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and copayments are due the day the treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim.

REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL. Once payment is received on your claim, we will send you a bill of any remaining balance on your account.

At our discretion, any unpaid balance after 90 days will be sent to collections at which the patient is responsible for any fees associated with the collection for the balance.

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12344 Roper Blvd
Clermont, FL 34711
(352)242-1763
AdminNorth@clermontsdentist.com
ClermontsDentist.com

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I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms above.

As a courtesy to our patients, Clermont Family Dentistry keeps a credit/debit card authorization on file for each patient visit and will charge the card for any balance not paid by your insurance for that visit only. Clermont Family Dentistry will also automatically refund your card if there are any amounts owed to you. If you have provided us your email address, you will receive an email with the receipt for any charge or refund. If your visit has a $0 balance, then there will be no further charge or refund.

The security of your personal information is very important to us, which is why your credit/debit card data is stored securely by Rectangle Health in a PCI DSS compliant credit card system, as required by VISA, MasterCard, American Express, and Discover. Clermont Family Dentistry's clinic staff do not have access to your credit card information, and the data is not stored on any Clermont Family Dentistry's computer system.

Payment Authorization

I authorize Clermont Family Dentistry to charge my credit/debit card for any outstanding patient responsibility balances that remain after insurance reimbursements have been applied for authorized dental services received at Clermont Family Dentistry. I also authorize Clermont Family Dentistry to issue a refund to the same credit/debit card if there is a balance due to me. I understand that I will be billed directly by, and agree to pay, Clermont Family Dentistry for any outstanding balances should my credit/debit card be declined or cancelled.

I also agree to reimburse Clermont Family Dentistry the fees of any collection agency, which may be up to 40% of the balance owed, along with all costs and expenses, including reasonable attorneys' fees, if incurred in such collection efforts. If my account is sent to collections, such fees will be assessed by the collection agency on behalf of Clermont Family Dentistry. Similarly, I understand that I may be responsible for my balance due to any chargeback, reversal, or dispute as a result of my credit card company's or bank's refusal to remit payment to Clermont Family Dentistry.

Patient Name: _____ Date: _____

Patient Signature: _____

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