NORTHSHORE FAMILY DENTISTRY

OUR FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE, AND WE ARE PLEASED TO DISCUSS OUR PROFESSIONAL FEES WITH YOU AT ANY TIME. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY OR YOUR RESPONSIBILITY.

ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE THEIR VISIT ***FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD AND DISCOVER.***

MISSED APPOINTMENTS

UNLESS CANCELLED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE FOR MISSED APPOINTMENTS AT THE RATE OF A NORMAL OFFICE VISIT PLEASE HELP US SERVE YOU BETTER BY KEEPING SCHEDULED APPOINTMENTS.

DENTAL INSURANCE

IF YOU HAVE INSURANCE, WE WILL HELP YOU RECEIVE MAXIMUM BENEFITS. ***WHEN WE ACCEPT YOUR INSURANCE, YOU MUST PAY AT LEAST YOUR DEDUCTIBLE PLUS YOUR ESTIMATED INSURANCE CO-PAYMENT AT THE TIME OF SERVICE. IF YOUR INSURANCE COMPANY HAS NOT PAID THE FULL BALANCE WITHIN 45 DAYS YOU HAVE 15 DAYS TO PAY THE BALANCE. LATE PAYMENT CHARGES ARE ADDED TO UNPAID ACCOUNTS AFTER 60 DAYS FROM DATE OF SERVICE AT THE RATE OF 1% OF UNPAID BALANCE PER MONTH.*** *IF YOUR ACCOUNT IS TURNED OVER TO COLLECTIONS, THE COLLECTION AGENCY FEES WILL BE INCLUDED IN THE AMOUNT TURNED OVER. IF YOUR INSURANCE COMPANY PAYS MORE THAN THE BALANCE DUE, WE WILL SEND A REFUND CHECK OR CREDIT YOUR ACCOUNT IMMEDIATELY*

I UNDERSTAND THAT MY DENTAL INSURANCE IS A CONTRACT BETWEEN ME AND THE INSURANCE COMPANY AND NOT BETWEEN THE INSURANCE CARRIER AND THE DENTIST THEREFORE, I AM STILL RESPONSIBLE FOR ALL DENTAL FEES. I UNDERSTAND THAT I WILL BE CHARGED FOR ALL DENTAL TREATMENT AND THAT ANY PAYMENTS RECEIVED BY THE DENTAL OFFICE FROM MY INSURANCE COVERAGE WILL BE CREDITED TO MY ACCOUNT OR REFUNDED TO ME IF I HAVE PAID THE DENTAL FEES INCURRED. WE FILE INSURANCE CLAIMS AS A COURTESY TO OUR PATIENTS. WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE COMPANY REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED CHARGES, SECONDARY INSURANCE, "USUAL AND CUSTOMARY" CHARGES, ETC., OTHER THAN TO SUPPLY FACTUAL INFORMATION AS NECESSARY YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

RESPONSIBLE PARTY SIGNATURE: _____

RESPONSIBLE PARTY NAME (PLEASE PRINT): _____ *DATE:* _____