OFFICE POLICIES AND FINANCIAL AGREEMENT

It is our desire to make high quality dental care affordable for everyone. The established financial policy of this office is that full payment is due at the time of service. However, we accept assignment of benefits on most major insurance policies, and also have charge plans available should you need to make extended payments on your account. The following is a statement of our Financial Policy which we require that you read, agree to and sign before any treatment. If you have any questions or concerns about our Financial Agreement please do not hesitate to ask our staff.

PAYMENT OPTIONS: We are pleased to offer extended payment plans and 12-month interest free financing. This allows our patients to make monthly payments instead of having to pay in full at the time of service. If you would like to make extended payments for services provided at our office, simply fill out an application form to establish your line of credit. There is NO CHARGE for completing the application and there is NO ANNUAL FEE.

Please mark whether you have insurance or not. Then choose one of the payment options.

_____ I DO NOT HAVE DENTAL INSURANCE.

_____ I would like to pay by cash, check or credit card at the time of service.

_____ I would like to apply for an extended payment plan through CareCredit or AIG.

_____ I HAVE DENTAL INSURANCE.

_____ I would like to pay my estimated portion by cash, check or credit card at the time of service.

_____ I would like to apply for an extended payment plan through CareCredit or AIG.

DENTAL INSURANCE: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage; however, we can make no guarantee of any estimated coverage or payment. Most dental insurance plans do not cover 100% of the cost of your treatment. All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Because the insurance policy is an agreement between you and your insurance company, we ask that all patients be responsible directly for all charges. Please know that we will do everything possible to see that you receive full benefits of your policy.

RETURNED CHECKS: A $25.00 charge applies when a check is returned by the bank.

OVERDUE BALANCE: An account with an unpaid balance past 90 days will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debts including attorney fees, court fees and any other fees associated with the collection of your debt.

We understand temporary financial problems may affect timely payment of your balance. In those situations we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

APPOINTMENTS: In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We do charge a $35.00 fee when people fail to keep their appointments or cancel without at least 24 hours notice.

CONSENT & AUTHORIZATION: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Paul Neumann, DDS. Without any reservations, I agree to abide by the policies outlined herein.

Form completed by:

Print Name:_____ Patient's Signature: _____
(Parent if Minor)

Date: _____

Reviewed by staff member: _____ Date: _____