FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

The person financially responsible for the patients' account must complete the Account Information on the reverse side before the patient sees the doctor.

- *FULL PAYMENT IS DUE AT THE TIME OF SERVICE.*
- *We accept:*
  - *Cash*
  - *Checks*
  - *Credit Cards*

  Ultimate Dental care Office Accept: Visa, MasterCard or Discover.

REGARDING INSURANCE:

- We require deductible and copays to be paid at the time of service.
- *Your insurance policy is a contract between you and your insurance company.* However, we will automatically bill your insurance company for services rendered as a courtesy to you.
- If your insurance company has not paid the total claim within 90 days from the date of your treatment, the balance will automatically be billed to you. Please be aware that we may receive only a partial amount of what was totally billed to your insurance company. You will be responsible for amounts the insurance company has determined as ineligible or not covered in full.
- If we cannot verify eligibility prior to treatment, you are expected to pay in full at the time of service. We will be glad to submit your insurance form and direct your insurance company to make payment directly to you.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit card, or payment by cash or check at time of service has been verified.

MISSED APPOINTMENTS:

Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $25.00. Please help us serve you better by keeping scheduled appointments.

LATE FEES:

If your payment is not received on or prior to the due date on your statement, a late fee of $25.00 will be added to your account. (For orthodontic patients, late fees are printed directly on your coupon payment books.)

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the Financial Policy.

_____ _____

Signature of Responsible Party Date

ACCOUNT INFORMATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

Guarantor's Name (Last – First – Middle)	Date of Birth	Martial Status S M D W	Today's Date

Address (Street) (City) (State) (Zip)	Home Phone
	( )

Name of Employer	Occupation	Work Phone (Ext.)
		( )

Employer Address (Street) (City) (State) (Zip)	Social Security No.

Spouse's Name (Last – First – Middle)	Date of Birth	Name of Employer	Work Phone (Ext.)
			( )

Dependent(s) Name (Last – First – Middle)	Date of Birth	Social Security No.	Home Phone
Name:			( )
Name:			( )
Name:			( )

Dependent(s) Address (if different) (Street) (City) (Zip)

Whom May We Thank for Referring You to Us?	E-Mail Address (For Appointment Confirmation & Specials in the future)

INSURANCE INFORMATION

Primary Insurance Name	Address (Street – City – State – Zip)	Phone No.
		( )

Name of Insured	Relationship	I.D. No.	Group No.

Secondary Insurance Name	Address (Street – City – State – Zip)	Phone No.
		( )

Name of Insured	Relationship	I.D. No.	Group No.

I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefit otherwise payable to me. I understand that my dental insurance carrier may pay less than the amount due for services. I hereby agree to pay in full any amounts that are not paid by my insurance carrier within 90 days after services are rendered on my behalf or my dependents.

Signature _____ Date _____