

## **Financial Policy**

Policy: Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks and credit cards (Visa, MasterCard and American Express). There is a \$25 returned check fee due and payable from you for each check payment returned to us by your bank. Financing is available through a third party payment service and arrangements must be made prior to scheduling treatment.

For Patients with Insurance: As a service to our patients, we will accept “assignment of benefits” and will bill your insurance carrier, assuming proper paperwork is provided to us. We will also assist you in billing your secondary insurance carrier, if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles which are due at the time of service, but the ultimate responsibility for any unpaid balance rests on you. If you have been treated by any other dental professional you must let us know so accurate insurance benefits can be calculated. Insurance is a contract between you and your insurance company. If an insurance carrier has not paid a claim within 60 days of billing, any unpaid professional fees are due and payable in full from you. Interest of 18% APR is charged on all account balances over 60 days old. Any unpaid balance over 90 days old without financial arrangements will be turned over to small claims court.

Treatment: Costs incurred while under the care of a specialist (endodontist, oral surgeon, etc...) are your responsibility. We offer estimates only, the final cost of treatment is determined by the specialist.

Unforeseen changes in treatment can occur. You will be notified of any changes in fee. Please be aware that the parent who brings in an under age child is responsible for all co-payments for that dependant child.

If treatment is abandoned prior to delivery of the final appliance, you will be billed for time at Dr. Hibbard’s hourly rate of \$450.

Often times treatment plans exceed the limits of an insurance policy limit. If you do not want treatment performed over the maximum it is your responsibility to schedule accordingly. Treatment warranty honored if recall visits are maintained at the prescribed intervals and all recommendations are followed.

Financial Agreement and Authorization for Treatment: I authorize treatment of the person named above and agree to pay all fees and charges for myself and members of my family shown by statement, promptly upon presentation thereof, unless credit arrangements are agreed upon in writing. Charges are shown to be correct and reasonable unless protested in writing within thirty (30) days of billing date. In event legal action should become necessary to collect an unpaid balance due for dental services rendered to me or my family, I/We agree to pay reasonable attorney’s fees and other such costs as the Court determines proper.

Failed/ Broken Appointments without 24hrs notice- \$25 - \$50 charge.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_