BRIDGEPOINTE FAMILY DENTISTRY, LLC

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FINANCIAL POLICY

THANK YOU FOR CHOOSING US AS YOUR DENTAL CARE PROVIDER...

The primary goal of our dental practice is to provide the highest quality oral health care in the most gentle, efficient and enthusiastic manner. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we require you to sign prior to any treatment. We are glad that you are here and we want to do our very best to ensure a pleasant and rewarding experience.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. **BRIDGEPOINTE FAMILY DENTISTRY, LLC** accepts CASH, PERSONAL CHECKS, VISA, MASTERCARD, DISCOVER AND CARE CREDIT. There is a $30 charge for returned checks.

OUTSTANDING BALANCES

Patients with an outstanding balance of 30 days or more must make arrangements for payment prior to scheduling appointments. Amount due and not paid in full within 30 days will be charged interest at a rate of 1.5% per month. Balances not paid after 90 days are subject for submission to a collection agency. In this case, in addition to the fees owed, the patient will be responsible for all fees charged by the collection agency for the costs of collection.

MISSED APPOINTMENTS/CANCELLATIONS

Appointment time is reserved exclusively for the scheduled patient. We do not double book appointments because we believe that you deserve our undivided attention. By giving 24 hour notice of appointment changes or cancellations, other patients who will need our time and care can be appointed. If 24 hour notice is not given, a $50 charge will be billed to the patient.

INSURANCE

In order for us to file your insurance we must have a copy of your current insurance card. If you do not have your insurance card at the time of service, full payment is due at the time of service.

You are responsible for all co-pays and deductibles.

Filing insurance claims is a service we provide free of charge but in no way relieves you from the responsibility of your bill.

It is your responsibility to know your insurance policy rules and benefits.

Please note: We file claims to several different insurance companies, and it is virtually impossible to know your individual insurance policies. We will do our best to give you a *rough estimate* of your investment in your dental health for each upcoming visit, based on your individual treatment plan. You will be given a very close *estimate* of your next visit's total bill.

Your treatment plan is individually tailored, and is not based on your dental insurance benefits or lack of benefits.

Not all services are a covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. *It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy.* Coverage issues can only be addressed by your employer or group plan administrator. We cannot act as a mediator with the carrier or employer.

Our staff is trained to help you with questions you may have relating to how your claim was filed, or regarding any additional information your carrier may need to process your claim. Please ask if you have any questions.

Your claim will be filed immediately, and benefits are expected to be paid within 30 days. The filing of an insurance claim does not relive you of timely payment on your account. If the claim is not cleared by your carrier in 45 days, the unpaid portion will automatically become self pay and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance chooses not to pay for whatever reason. Any amounts expected to be paid by your insurance company, but not cleared by them within 45 days become your responsibility, and if it is not paid in a timely fashion, will begin to accumulate interest at the rate of 1.5 % per month.

I understand and accept the financial and the dental insurance policies listed above and have had any and all questions answered to my satisfaction. **I agree** to pay for all treatment in a timely fashion as described so as to avoid any additional fees.

I hereby authorize my insurance benefits to be paid directly to Bridgepointe Family Dentistry, LLC. I realize that I am responsible to pay for any deductible amounts, my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by said insurance and I agree to pay such charges in full. I also hereby authorize the release of pertinent medical/dental information to the insurance carrier(s). This order will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

X_____

PATIENT (or parent of minor) DATE

X_____

STAFF INITIALS