JONES
DENTAL CARE

FINANCIAL POLICIES

We are dedicated to providing you with the best possible dental care. To give our patients this level of customer service will require that we have some financial and insurance policies. It is important that you read carefully and understand each of the following statements.

INSURANCE

We help file your insurance claims as a courtesy and a convenience to you. **Your insurance coverage is a contract between you, your employer and the insurance company.** We are not a party to this contract. **Our relationship is with you and not with your insurance company. All charges are your responsibility.** Our office will submit your dental claims to your first and if applicable your secondary insurances as a courtesy. It is your responsibility to provide us with the correct current insurance information and to understand your benefits and monitor what has been paid to our office should you be close to using up your benefits. It is also your responsibility to confirm that the doctor you are seeing is on your insurance provider list and to obtain referrals if necessary.

CHARGES

We require all deductibles and co-payments to be made at the time of service. If payment is not made at the time of service, there will be a **delayed payment fee of $25.00. Your appointment may also be rescheduled and there could possibly be a fee for the loss of doctor or hygiene time.** We have no control over what your insurance company will or will not choose to pay. We will estimate your dental treatment to the best of our ability. However, all charges for treatment are ultimately the patient's responsibility. There is an interest rate of 24% APR (2% added to balance monthly) on **ANY** unpaid balances, including delayed insurance claims. If your account becomes 90-day delinquent, the account will automatically be sent to a collections agency. A 50% service fee will be assessed.

APPOINTMENTS

We require that all patients confirm any appointments they have made with the office. If appointments are not confirmed, the office may cancel those appointments. There may be a charge of $60 per hour of the doctor or hygiene time if you are not able to give the office a 2-business day notice of cancellation.

I grant permission to the staff to telepone me at home, work or on my cell to discuss matters related to this form. I have read, understand and agree to the policies listed above.
(minors must have signature of parent or guardian before being seen)

SIGNATURE _____ DATE _____