FRICK & JONES, PA

PRACTICE LIMITED TO PERIODONTICS

We would like to welcome you to our office. It is our policy to provide excellent quality care to our patients and to run our practice efficiently. We ask your cooperation by assisting us with our financial policy.

Full payment is due when services are rendered. As a courtesy to those patients with insurance, we will file your primary and secondary insurance. **THE ESTIMATED AMOUNT NOT COVERED BY THE INSURANCE WILL BE CALCULATED AND THAT AMOUNT IS PAYABLE ON THE DAY SERVICES ARE RENDERED**. This estimate is either based on past history of benefits from your plan or information supplied by you pertaining to your plan. Most insurance companies have their own schedule of what they consider "USUAL AND CUSTOMARY" (UCR) fees. These fees can vary greatly among different plans. Our fees are based solely on the amount of time, skill, and care required to treat your particular case and is not based on your insurance coverage. Therefore, it is not uncommon to find differences in our fees and insurance fee schedules. Please understand that your insurance is an agreement between you, your employer, and your insurance carrier. **WE ARE NOT A PARTY TO THAT AGREEMENT**.

Insurance Authorization and Assignment

I hereby authorize Drs. Frick & Jones to furnish information to insurance carriers concerning my treatment and I hereby assign to the periodontist all payments for services rendered to me or dependents. I understand that I am responsible for payment at time of service and that my insurance will be filed as a courtesy on my behalf.

Signature of Policyholder: ____

Once insurance is filed, we will allow 45 days from the date of service for insurance to respond. At that time the patient will be billed directly. Any balance that is outstanding will become the patient's responsibility. Interest will accrue at the rate of 1.0% per month for any account over 90 days old.

Our office accepts cash, checks, MasterCard, Visa, Discover and American Express. Any returned check will generate an additional fee of $30.00.

IT IS IMPERATIVE THAT ALL APPOINTMENTS ARE KEPT AND PATIENTS ARE ON TIME. PLEASE CALL OUR OFFICE AT LEAST 24 HOURS IN ADVANCE TO CANCEL OR RESCHEDULE APPOINTMENTS.

I have read, understand and agree to the above policies.

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Patient Signature (Parent or Guardian if under age) Date