

FINANCIAL POLICY

Thank you for choosing our office for your dental care. We are committed to providing the highest quality dental care through the use of state-of-the-art technology, equipment and training. At all times, you can be confident that we will always recommend and provide you with our best services without regard to the limitations imposed by your insurance coverage. Our practice is “health centered” rather than “insurance centered”. We hope that by providing you with our policies in advance we can prevent misunderstanding and frustration. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

Please understand that payment of your bill is considered a part of your treatment.

Full payment is due at time of service. We accept cash, checks or Visa/Master Card/Discover/American Express. We also offer various dental financing options as an extended payment option. Ask our staff for details.

Insurance

As a courtesy, we obtain basic benefit eligibility from your insurance so that we can offer you an **estimate** of your benefits. The estimated percentage not covered, including any deductible, is to be paid at the time of service.

Please be aware that you are fully responsible for understanding your plan and exclusions and how it relates to your dental procedures. At any time, if you have questions regarding your plan as it relates to your treatment, we will be happy to try to answer to the best of our knowledge. *However, it is your responsibility to verify plan benefits coverage of service with your insurance company.*

If your insurance plan does not cover procedures as estimated for any reason, the portion not covered is your responsibility at 60 days of non-payment from the insurance company. In an event that your insurance should pay us after that time, you will be reimbursed.

We will file your insurance if we are able; however we need the following information to offer you this service (most of the time this information is provided on your insurance card or from your employer’s HR):

- Name of Insurance and Phone Number
- Employer of Policy Holder
- Member Number and Social Security Number
- 1-800 # for Insurance Company
- Group Number
- Patient DOB and/or Policy Holder DOB
- Eligibility Date

If your plan has a fee schedule you are responsible for providing that to our office prior to your appointment.

Our office files insurance for our patients as a courtesy. We make no claim to know what services your insurance covers, while we make a good faith attempt to verify coverage we are not able to guarantee that the information given to us by your insurance is correct. Please keep in mind your contract is between you and the insurance company. Your involvement in the process of providing us with proper information, and you being proactive in knowing your plan, will help us maximize your benefits to their full potential. We encourage you to refer to your benefits manual or customer service if you have any questions about covered services. You are responsible for payment regardless of your insurance company’s determination of usual and customary rates, if our office does not participate in your plan.

Regarding PPO insurance plans, it is your responsibility to be sure we are a participating (in network) provider on your dental plan.

Regarding DMO insurance plans, which are reduced fees, there is no reimbursement for services from your insurance company. The reduced fee and presentation of your insurance card or verification of coverage is required at the time of treatment.

Minor Patients

Minors must be accompanied by a legal guardian at their initial visit and by adult at all subsequent visits. The legal guardian is responsible for full payment of services at the time of treatment. Should the recommended plan of treatment change, approval is required of the legal guardian. If the legal guardian is not present at subsequent visits, he or she must be available by phone in the event of an emergency to approve any changes in treatment, or for any other reason that may arise. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized. The legal guardian is required to notify our office of any changes in the minor's medical history prior to treatment.

Divorce Decrees

This office is NOT a party to your divorce decree. The legal guardian who accompanies the minor at the appointment is responsible for payment.

Interest, Rebilling, Collection Fees and Returned Checks

Interest in the amount of the 18% APR will be charged to any remaining balance after 60 days. If your account is turned over to a collection agency, in addition to interest, you will be charged a collection fee. Our bank charges us for insufficient funds of a deposited check, therefore you will be charged \$30.00 for returned checks.

Missed Appointments

Unless canceled on a business day at least 48 hours in advance there will be a \$50 missed or late cancellation fee. We reserve the right to have future appointments prepaid or not pre-book your appointments but allow you to be on a cancellation list. If you miss 3 missed appointments without adequate cancellation time, you may be dismissed as a patient from the practice. If you arrive more than 15 minutes late for your scheduled appointment, you may be asked to reschedule your appointment to another time and/or day and be subject to the missed appointment fee.

I have read, understand and agree to abide by the terms stipulated in the above Financial Policy.

	X	
Printed Name of Patient	Signature of Patient	Date

If legal guardian please complete below:

Signature of Legal Guardian _____
 Printed Name Legal Guardian _____
 Address _____
 City/State/Zip _____
 Phone # _____
 Cell # _____
 Employer _____
 SS# _____ DOB _____
 DL# _____ Sex: M or F

11615 Angus Road, Ste. 210 Austin, TX 78759 Phone: 512.795.9643 Fax: 512.795.9959	893 N. IH-35, Ste.200 Round Rock, TX 78664 Phone: 512.310.9374 Fax: 512.244.3954	6211 William Cannon Dr. #A Austin, TX 78749 Phone: 512.288.4447 Fax: 512.288.4774
--	---	--