PETER R. BROWN, DMD

3 KACEY COURT, STE. 202
MECHANICSBURG, PA 17055

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our financial policy with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

If you do not have insurance, we expect payment in full for all services at the time of your visit unless other arrangements have been made. We accept cash, checks, Visa, MasterCard, and Discover.

APPOINTMENT POLICY

We value everyone's time and strive to see patients in a timely manner. In order to do so, appointments are considered "reservations"; therefore, we require a 24 business hour cancellation notice. **If we don't receive that notice a $40.00 broken appointment fee will be charged to your account.**

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. Your insurance claim will ONLY be completed and submitted if we are provided with all pertinent insurance company information. It is **your responsibility** to verify that your policy is in force on your date of service. Otherwise, you are responsible for payment at the time of service.

Insurance is an agreement between you and your insurance company. We will inform you if we are participating with your insurance company and will handle your claim according to our agreement with the insurance company. **We file insurance claims as a courtesy to you, our patient.** We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances "usual and customary" charges, etc., other than to supply necessary factual information. **Deductibles and/or co-payments need to be paid at the time of service. You are responsible for the prompt payment of your account.**

AGREEMENT

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that, unless I have been making prompt payment, my account may be turned over to a collection lawyer for collection after 90 days. At which time I will be responsible for any added attorney or court costs. Delinquent payment history may also be reported to the Regional Credit Bureaus.

Print Patient Name: _____

Responsible party signature_____Date_____