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Avon, IN 46123
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Hometown Family Dentistry
Stephanie D. White, D.D.S.

FINANCIAL POLICY AND PATIENT PAYMENT AGREEMENT

Our financial relationship is with you, the patient. You, not your insurance company, are ultimately responsible for the payment of all fees charged. Cash, check, debit cards, or credit card payments are accepted.

If you have dental insurance, we will accept assignment from your insurance company (if they allow it) for any covered treatment. We require payment in full for any uncovered portion (co-payment) of your care and your deductible at the time of your appointment. An estimate of the amount due from you will be calculated when the appointment is scheduled.

If you do not have insurance or we cannot verify eligibility from your insurance, payment is due in full at the time of the treatment. _____

MISSED APOINTMENTS - LATE CANCELLATIONS – LATE ARRIVAL

When you schedule an appointment with us we reserve this time exclusively for your care. We will do our best to confirm your appointment; however, it is your responsibility to keep the appointment. A fee will be charged for consistently missed appointments, late arrivals, or late cancellations. We require 48 hours notice for all cancellations. _____

FINANCE CHARGE

I understand that any unpaid balance after 60 days will be charged a yearly finance charge of 18% which is equal to 1.5% of my outstanding balance per month. _____

Should my account reach collection status of 60 days and I make no effort to pay off my balance, my account will be assigned to a collection attorney or agency. If my account is assigned to a collection agency, I agree to pay the cost of collections which include the balance plus additional 50% fees, including court costs and attorney fees incurred by Hometown Family Denistry. _____

Thank you for taking the time to read and understand our financial and appointment agreement. Our practice is committed to providing the best care for our patients. Please let us know if you have any questions. Our financial coordinator would be glad to review the agreement with you at any time.

_____ DATE:
Signature Name of Patient, Parent, or Guardian

_____ DATE:
Signature Name of Witness