

J. Scott Anderson D.D.S., P.L.L.C
Financial Guidelines

We value you as a patient and are committed to providing you with the best possible dental care. We want you to have a complete understanding of your financial responsibilities for the services to be provided. To assist us in achieving these goals, we ask that you review our financial policy.

Unless payment arrangements have been approved in advance by authorized staff, payment in full will be due at the time services are rendered. **We do not balance bill.** We will be happy to process your dental insurance claim, and by signing this form you are giving authorization for the insurance company to pay us directly for any treatment rendered.

At the time of your appointment, you will be expected to pay your deductible as well as any portion of the treatment fees that we estimated will not be covered by your dental insurance. Due to insurance policy changes and/or necessary changes in treatment plans, your dental coverage may vary from this estimate and calculations on the insured pre-estimate. If your insurance company has not paid in full in 60 days from treatment day, you will be responsible for paying the balance.

Please remember that your insurance is a contract between you and your insurance company and/or employer. Our dental practice is not a party to the contract. We recommend that any questions regarding the amount of coverage for specific treatment be discussed directly with your insurance company or employer.

A finance charge of 1.5% per month may be assessed to any outstanding balances over 30 days from the date of treatment. (This finance charge represents an Annual percentage rate of 18%). If your check is dishonored or returned for any reason you expressly authorize our office to electronically debit your bank account for the amount of the check, plus a **\$25.00 NSF** processing fee. Your use of a check for payment is your acceptance of this agreement and its terms.

All treatment charges are the responsibility of the patient or responsible party regardless of insurance coverage. In the event of non-payment, the patient or responsible party agrees to pay all cost of collections including but not limited to attorney fees, court cost, collections agency fees, ect...

ALL SEDATIONS CASES MUST BE PRE-PAID, NO EXCEPTIONS CAN BE MADE.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY OF THIS PRACTICE AND AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT SUCH TERMS MAY BE AMENDED FROM TIME TO TIME BY THE PRACTICE AND THAT BY SIGNING THIS POLICY GIVES THE INSURANCE COMPANY MY PERMISSION TO PAY J. SCOTT ANDERSON D.D.S DIRECTLY FOR DENTAL SERVICES

SIGNATURE OF
PARENT/PATIENT/GUARDIAN _____

DATE _____