



ADVANCED
DENTISTRY
THE ART OF THE SMILE

Financial and Insurance Policy

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial and Insurance Policy is important to our professional relationship.

- All patients must complete the "Patient Information & Medical Form" before being seeing the doctor.
- Full payment is due at the time of service unless other arrangements are made.
- Twenty Four hour notice is required when re-scheduling or canceling appointment.
- For your convenience, we accept CASH, PERSONAL CHECKS, ATM DEBIT PAYMENTS, VISA and MasterCard. A financial payment program is also available through "CAPITAL ONE".

MONTHLY STATEMENTS

A monthly statement with current charges and payments, including insurance billing payments will be sent to you. Pending estimated insurance benefits will appear on your statement until we receive payment from your insurance company. Billing Fees of 1.5% per month are added to all unpaid balances after 90 days from date of service.

Should legal action required to obtain payment, the undersigned patient/responsible party agrees to pay court costs and attorney fees.

INSURANCE ASSIGNMENT

As a convenience to you, we will be happy to submit your insurance claims. The insurance company, not our office, determines the dental benefits that you will receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges incurred are your responsibility. Please keep your insurance information current by notifying us in writing of any changes in employment, insurance coverage. etc.

I have read, understand and agree to the above. I hereby authorize Advanced Dentistry and/or the dentist(s) in charge of my care, to submit and to sign insurance claims on my behalf. I hereby authorize the release of any information, pertinent to my case, to my insurance company or their agents. I understand that this authorization is a direct assignment of my rights and benefits under my policy and that payment will be made directly to "Advanced Dentistry".

PATIENT OR GUARDIAN'S SIGNATURE: _____ DATE: _____