FINANCIAL POLICY

We are committed to providing you and your family the best dental care possible. Our dental office does require that you understand and accept our financial policy prior to the commencement of any dental procedure that takes place in this office. Acceptance of this policy requires you to place your initials in the required line and to sign and date the bottom of this form.

If you do not have dental insurance: Payment in full is required at the time services are rendered. As an incentive, we offer a 5% discount for those without insurance. We accept cash, checks, and major credit cards for payment. We do not offer payment plans; however, we do accept Care Credit.

(Please initial_____)

If you have dental insurance: As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan

All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract

(Please initial_____)

Your estimated portion is due at the time services are rendered. We accept cash, checks, Care Credit, and major credit cards for payment. If circumstances require that you be billed for the estimate portion, payment will be required 30 days from the date that services were rendered. Returned checks and balances older than 30 days will be subject to additional collection fees and interest charges of 1.5% per month (18% annually)

(Please initial_____)

We are happy that you have chosen Shull Family Dentistry to care for your dental needs. Please do not hesitate to ask at any time if you have questions regarding the information above. Please sign and date the bottom of this form. Thank you for your understanding and cooperation in this matter.

By signing below, I have read the above and agree to the terms of this financial policy.

_____ _____

(Signature of Patient or Legal Representative) (Date)