OHIO FAMILY DENTISTRY

Ohio Family Dentistry
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FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment.

Payment

Payment is due at the time of treatment unless prior arrangements have been approved. We accept the following forms of payment: Cash, Visa & MasterCard. Our office also works with Care Credit to assist you with your payment needs.

Insurance

Your dental insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be back dated. Most benefits will be verified before your insurance company can be billed. All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Missed appointment:

Unless cancelled 48 hrs in advance our policy is to charge **$50.00** for missed appointment at our discretion.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.
I also assign directly to Dr ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. The above named dentist may use my health care information and disclose information to the insurance company(ies) and their agents for the purpose of obtaining payments for services and determining insurance benefits.

Patient/Responsible Party Signature: ____ Date: __________________

Print Name ____

Patient/Responsible Party Name: ____ Date: __________________

Print Name ____