ROBERTS DENTISTRY FINANCIAL POLICY

I understand that all responsibility for payment for dental services provided in this office for my dependents or myself is mine and will be due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge may be added to my account. I further agree to pay all finance charges, collections costs, attorney's fees, and any other cost that may be incurred to enforce collection of any amount outstanding.

I understand that my insurance coverage is a contract between my employer and the insurance company. Not all services are a covered benefit. Some insurance companies arbitrarily select certain procedures they will not cover. Roberts Dentistry emphasizes that as a dental care provider, their relationship is with me, and not my insurance company. They will file your insurance claim is a courtesy we extend to all our patients.

I understand this office can make no guarantee of any estimated coverage or payment by my insurance company. In the event my insurance does not pay within 45 days from the date the claim is submitted by Roberts Dentistry, I will be responsible for the total obligation. It is also my responsibility to know my dental benefits. Roberts Dentistry will provide an estimated treatment plan, however, it is an estimate only.

I hereby instruct and direct my insurance company to pay direct payment to Roberts Dentistry for services rendered by Roberts Dentistry. I authorize Roberts Dentistry to initiate a complaint to the insurance commissioner for any reason on my behalf.

I understand Roberts Dentistry offers many forms of payment. Most major credit cards are accepted, cash, checks, and care credit.

I understand that if I elect not to provide my social security number, I will provide a copy of my driver's license and/or legal form or photo identification.

I understand that it is my responsibility to advise this office of any changes in the information I provide regarding my insurance, patient information, or the health history form.

I understand that my appointment time has been especially reserved for me and in the event that I need to reschedule, I will give a 24-business hour notice. Failure to do so will result in a cancellation fee.

I understand that fees are applicable for dental records and/or copies of dental x-rays.

I understand that there will be a $20.00 in-sufficient funds fee added to my account in the event of a returned check.

Patient Signature ______________________________ Date ___________________