

# Financial Policy

Thank you for choosing **21<sup>st</sup> Century Dental Care, P.C.** as your health care provider. We are committed to your treatment being successful. The following is a statement of our **Financial Policy**, which we require you to read and sign prior to any treatment. Please understand that this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**

**WE ACCEPT CASH, CHECKS, AND ALL MAJOR CREDIT CARDS.**

**INSURANCE:** We may accept assignment of primary insurance benefits; however, we do require deductibles and co-payments be paid at the time of service. The balance is your responsibility. Your insurance policy is a contract between you and your insurance company; we are not a party to that contract nor are we responsible for procedures that are not covered for any reason. We must have **complete** and up to date insurance information in order to bill your insurance company on your behalf. In the event that your insurance company has not paid their portion within 45 days, the balance will become your responsibility.

**USUAL AND CUSTOMARY RATES:** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary fro our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.

**MINOR PATIENTS:** The parents or guardians accompanying a minor are responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized to a credit card or payment by cash or check at the time of service.

**FINANCE CHARGES:** A finance charge will be billed to any account in which the balance remains unpaid for 30 days without payment arrangements. This monthly fee will equal 18% APR from the date the payment was due.

**COLLECTION FEES:** When an account becomes 60 days past due, collection action may be taken outside of 21<sup>st</sup> Century Dental Care, P.C. In this event, you will be responsible for all collection and legal fees, which may equal 50% of the total balance plus legal fees.

**MISSED APPOINTMENTS:** Unless cancelled at least **24 hours** in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us to serve you more efficiently by keeping scheduled appointments.

**RETURNED CHECKS:** If a check is returned NSF, there will be a \$35.00 charge and, from that point on, checks will not be accepted.

I, the undersigned, assume financial responsibility as stated above and responsibility for all collection and legal fees if my account becomes past due. I have read, understand, and agree to this **Financial Policy**.

X \_\_\_\_\_

**Signature of Patient or Responsible Party**

Date \_\_\_\_\_