Patient Name: ___________________

Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. Payment is due at the time service is provided. Our office accepts cash, personal checks, credit cards and outside patient financing.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%.

Do You Have Insurance?

- 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, your employer, and your insurance company.
- As a courtesy to you we will help you process all your 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**. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide service to you.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- All in house financing agreements upon statements over 30 days are subject to a 18% APR finance fee + a $2.00 Billing fee.
- Any outstanding balances greater than 90 days without payment are turned over to collections. We will provide statements and written warning should such event occur.
- Treatment plans over $1000 or greater require a 20% deposit to retain your scheduled appointment time. Deposit will need to be made at time of scheduling appointment.
- If an **appointment is canceled within 24 hours** of appointment time a no show fee will be assessed to your account. The fee is **$50/hr of** appointment time scheduled.
- If paying by credit card, credit card payers will be responsible for paying a 1-2.5% credit card transaction fee.
- Additionally, Michael and Jason Weber DDS Family and Implant Dentistry **does not** provide any sort of refund on services rendered. However, we do offer various warranties on services.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care to our financial policy.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself of my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges you many incur for an incoming call from us, and/or outgoing calls to us, to or from any such number without reimbursement from us.

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Patient Signature (Parent if child) *Date*