

OUR FINANCIAL POLICY

Thank you for choosing us for your dental needs. We are committed to providing you excellent care, and payment of your bill is part of successful treatment. Our Financial Policy is based on an open and honest discussion of our fees. Please read the following and sign at the bottom. You may request a copy of this agreement.

PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE. We offer three options of payment for the treatment that we provide:

1. We accept cash and personal checks.
2. We accept Visa, MasterCard, Discover Card, American Express and CareCredit (applications available at front desk).
3. We offer a limited monthly payment plan (Direct Debit) in accordance with the office credit guidelines. Financial arrangements must be made prior to treatment.

Insurance

If you do not have insurance, please be prepared to fully pay the fees for each visit. As a service to our patients, if you do have insurance, we will bill your insurance company if you bring in a completed original insurance form and all your insurance information. We ask that you pay or finance the portion of your treatment not covered by insurance, along with the deductible. Your insurance policy is a contract between you and your insurance company. As a health care provider, we are not party to that agreement. We require assignment of your insurance benefits to Dr. Walsh and that pre-approved arrangements be made on major dental work. Insurance policies vary and services provided may not be covered. We are available to answer your questions and help you maximize the benefits available to you. We will estimate the co-payment at each appointment; however **we make no guarantee of estimated coverage.** It is your responsibility to keep us updated on any changes of insurance and to make sure the charges we submit do not exceed your maximum benefit. If you fail to do so, it will be your responsibility to clear the outstanding balance.

Usual and Customary Rates

We are committed to providing excellent dental treatment to all our patients. Our fees reflect our commitment to the quality our patients deserve and are considered usual and customary for the area, regardless of any insurance company's determination.

Missed Appointments

THE POLICY OF THIS OFFICE IS TO CHARGE FOR MISSED APPOINTMENTS UNLESS THEY ARE CANCELED 24 HOURS IN ADVANCE. Once an appointment has been made, please remember this time has been reserved specifically for you. This better enables us to serve your needs.

Service Charges

The policy of this office is to charge service fees of 1.8% per month (21% ANNUAL PERCENTAGE RATE), \$1.00 minimum charge. There will be a \$25.00 charge for returned checks. Service charges related to Direct Debit Financing are outlined in that agreement.

Collection Fees

Fees and expenses, including reasonable attorney fees, incurred to collect payment will be payable by the patient.

Financial Consent

The patient or guardian agrees to be fully responsible for total payment of treatment performed.

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information required for claims. I authorize that my records can be used by the doctor if he so determines. In consideration of the service rendered to me by this dental office I am obligated to pay said in accordance with its credit terms and policies. I consent to the taking of photographs and x-rays before, during and after treatment and to the use of the same by the doctor in scientific papers and demonstrations.

Credit Request

I request consideration for credit policies extended by the Doctor and desire credit extended to me and/or my family for services rendered. I acknowledge that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient/responsible party

Date