Rocket City Dental
PATIENT FINANCIAL POLICY

To keep dental costs down, while maintaining a high level of professional care, we have established this financial policy for your benefit.

1. Payment for all treatment is due at the time services are rendered unless other payment arrangements have been made with our team in advance.

2. Payment for services may be made by cash, check, Visa, MasterCard American Express and Discover. We have made special arrangements with Care Credit for quick and easy applications for credit. If credit is approved, you will qualify for low monthly payments and a 0% interest fee for 6 months.

3. Fees quoted for treatment will remain in effect for 6 months and thereafter are subject to change without notice. Please note that all treatment plans are individually tailored and not based on insurance benefits or lack of benefits.

4. If you fail to show for a scheduled appointment or cancel an appointment with less than 24 hours advance notice, 72-hour advance notice for all Monday appointments, you may be charged a $50 fee for the broken appointment.

5. If a check provided by you to the practice in payment for services delivered is returned due to insufficient funds or otherwise there will be a $35 returned check fee added to the amount due.

6. If services are not paid for at the time services are delivered you will be provided a statement for the amount due and will be expected to pay that amount in full promptly following receipt of the statement. If the amount due is not paid in full within 30 days after insurance has processed the claim, you will be charged interest on the outstanding amount at a rate of 1.5% per month, or 18% annually. If the amount due is not paid in full within 60 days of the day services are delivered the practice may, among other remedies, refer the collection of the unpaid amounts to a collection agency or collection attorney.

If you have dental insurance the practice will work with you to maximize your allowable insurance benefits and will assist you in making necessary filings with your insurance company. Please remember that your insurance policy is a contract between you and your insurance carrier, the practice cannot assume responsibility for coverage or other determinations made by your insurance company and that you will be responsible for timely payment for all treatment received from the practice regardless of your insurance status.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Please note a pre authorization for services does not guarantee payment from your insurance carrier.

It is your responsibility to know if our office or an office we refer you to, is participating or nonparticipating with your insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obligated to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier. Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you are responsible for all out-of- network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy shall also cover your dependent children who are patients of the practice.

Patient Name: ___________________________________

Patient Signature: _________________________________

Date: ________________