The Dental Studio

FREDERICK

FINANCIAL POLICY

Welcome! Thank you for selecting us as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

FINANCIAL AGREEMENT:

Patients are expected to pay at the time services are rendered. Our patients, who have dental insurance, are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payments may be made using cash, check, Visa, MasterCard, Discover, and/or American Express. We also offer CARECREDIT which is a financing option that is available only for healthcare expenses. We will mail monthly statements to all patients with an outstanding balance charge of 1.5% per month past 60 days. After six months, delinquent accounts will be referred to a collection agency and may affect credit ratings.

APPOINTMENTS:

In order to serve you better and keep the cost of dental care down, we try to maintain an efficient appointment system. However, our cost of providing care increases when patients fail to keep scheduled appointments or cancel at the last minute. Therefore, The Dental Studio of Frederick reserves the right to ***charge a fee of $1.00 per minute of scheduled time for each appointment that is not cancelled with 24-hours advanced notice***. This fee will be billed to the patient and is not covered by dental insurance. Fees must be paid prior to your next appointment.

INSURANCE INFORMATION:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. In order to do this, we need your insurance card and/or insurance policy with you on your first visit of every calendar year. We also need to be informed promptly of any change in insurance coverage during the year.

Completion of treatment implies acceptance and consent on your part to the treatment. Any balance left unpaid by the insurance company is the patient's responsibility. If your insurance has not paid within 90 days of services rendered, we require you to make full payment to this office and be reimbursed when your insurance company pays.

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 will also cover your dependent children who are patients of the practice.

Patient's Name (please print) ____

Patient/Guardian Signature ____

Date ____

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