Patient Name: _____

DeSoto Family Dentistry

Financial Policy

This is an agreement between DeSoto Family Dentistry and the Patient named on this form.

By executing this agreement, you are agreeing to pay for all services that are received.

Insurance: Insurance is a contract between you and your insurance company. We are NOT party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges for services rendered but not covered by your plan or not paid (denied) by your insurance. You must inform us if you lose or are about to lose your insurance coverage. Any services rendered after insurance eligibility terminates will be charged at our standard fees.

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Patient Initials

Required Payments: A **non-refundable** payment is required at least 3 days prior to the day you receive your dental treatment. If you have dental insurance coverage, we will **estimate** your insurance co-payments required by your insurance company and it must be paid at the time of the service. As a courtesy we will file your insurance claims. If insurance denies a service, it will be the patient's responsibility to pay any outstanding balance after insurance has paid.

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Patient Initials

Statement: Should you end up with a balance on your account due to ***underestimation*** of your insurance co-payment, we will send you a statement. It will show the charges to the account. The finance charge, if any, and any payments or credits applied to your account.

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Patient Initials

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if payment is not received within 30 days.

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Patient Initials

Payment Options:

1) You may pay by cash, check, credit card, or third party financing 3 days before dental treatment is rendered.
2) On treatment involving crown and bridge work, dentures, root canals, etc. that require longer than an hour appointment times, you agree to put a **non-refundable** deposit of at least 35% of the dental fee or your co-insurance payment at least 3 days prior to appointment date and time is reserved for you.
3) On extensive treatment and treatments that exceed your plan's maximum insurance benefit payable, you may prefer to secure bank, credit union, or other third-party financing (Care Credit) for your out-of-pocket portion and make payment arrangements to the lending institution.
4) We offer 6-12 months no interest financing for qualified patients through a third party. They pay us your dental fees and if you pay them in full by the end of the term, they will not charge you interest.

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Patient Initials

Returned Checks: There is a fee (currently **$26**) for any checks returned by the bank. Returned checks not redeemed within 21 days will be turned over to collection and associated costs will be added to the balance due.

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Patient Initials

Missed Appointment Fee: If a patient cancels with less than 24 hours' notice, a **$25 per hour** late cancellation fee or for Treatment Appointments **10%** of appointment cost fee, will be charged. This fee must be paid before new appointment is scheduled for all patients under account.

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Patient Initials

Divorce: In the case of divorce or separation, ***the parent accompanying the child and authorizing treatment will be the parent responsible for the charges on the day of service.*** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

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Patient Initials

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account, unless other arrangements have been made with the office. The **FINANCE CHARGE** will be computed at the rate of one and a half percent (1.5%) per month or an **ANNUAL PERGENTAGE RATE** of eighteen (18%) percent. The finance charge is computed by applying the periodic rate (1.5%) to the "overdue balance" of your account.

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Patient Initials

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, or to a lawyer, you agree to pay all of the collection costs, lawyers' fees plus all court costs which are incurred. In case of suit, you agree that the venue shall be in Dallas County, Texas.

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Patient Initials

Credit History: If you default on your account, we have the option to report your account status to any credit reporting agency such as a credit bureau.

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Patient Initials

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

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Patient Initials

Transfer of Records: You must make a request in writing to obtain of your dental records. The fee to obtain your dental records is **$25.** Your request will be processed no earlier than five (5) business days but no longer than ten (10) business days from the time we receive your request. ***You authorize us to include all relevant information including your payment history.*** If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information including your payment history.

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Patient Initials

Emergencies: All workers compensation related claims and personal injury claims, regardless of insurance coverage are to be paid in full by cash or credit card only.

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Patient Initials

Co-Signature: if this or another Financial Policy is signed by another person, that co-signing remains in effect until cancelled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

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Patient Initials

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

_____
Patient Initials

_____	_____
Patient's Name	Responsible Party (if required)
_____	_____
Signature	Date
_____	_____
Co-Signature (if required)	Date