Adams & Cheek Dentistry

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing exceptional dental care to every patient! Please understand that payment for services rendered is considered a part of your treatment and also a part of that treatment being successful. After reading the following statements to familiarize yourself with the expectations of our patients, please provide your signature indicating that you fully understand these policies. This form must be signed in order to proceed with your scheduled appointment.

All patients must provide the requested information and complete all of the required forms before seeing the doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, PERSONAL CHECKS, MASTERCARD/VISA, DISCOVER & AMEX.
WE ALSO OFFER THIRD PARTY FINANCING OPTIONS THRU CARECREDIT UPON APPROVAL.

Insurance

As a courtesy to our insured patients, we will file all insurance claims on your behalf. It is your responsibility to provide and update your insurance information with us prior to your appointment. This allows us to verify the dental benefits for the scheduled appointment and any future treatment. ***Your insurance policy is a contract between you or your employer and your insurance company***. **We are NOT a party to that contract.** It is ultimately your responsibility to know the benefits, exclusions, frequencies and limitations of your specific policy. Every plan is different and changes may occur during the benefit period. We will provide you with the best course of treatment to care for you, not based on your insurance coverage, but based on your personal dental needs. All charges incurred are your responsibility, regardless of your insurance coverage, insurance payment or non-payment. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and/or necessary under your insurance plan.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of "usual and customary" rates (UCR).

Adult Patients

Adult patients are responsible for full payment at the time services are rendered; the same applies to any dependent(s).

Minor Patients

The adult, parent or guardian accompanying a minor to any appointment is responsible for full payment at the time services are rendered unless prior arrangements have been made.

Interest and Collection Costs

We reserve the right to charge interest on any unpaid balance over 45 days in the amount of 18% per annum. If it becomes necessary to retain an attorney to collect an overdue balance, you will be responsible for paying our reasonable attorney fees and the cost of collections.

Returned Check Fee

There will be a $25.00 fee for any returned checks. This fee is subject to change without notice.

Credit Balances

Should a credit balance on a patient's family ledger occur after treatment is rendered, we will keep the credit on the account to apply towards future treatment or refund the family ledger credit balance only upon request by the account guarantor.

I understand and accept the financial policies of Adams & Cheek Dentistry listed above and have had any and all questions answered to my satisfaction. I agree to pay for all treatment in a timely fashion as described to avoid any additional fees. I realize that I am responsible to pay for any deductible amount(s), my co-insurance portion and for any non-covered services. I understand that I am financially responsible for any and all charges of dental treatment and incurred fees, whether or not paid by insurance and I agree to pay such charges in full. This signed policy is also applicable to any member of my family that is a current patient or may become a future patient of this practice.

X_____

Patient or Responsible Party Name

X_____ Relationship: _____

Signature of Patient or Responsible Party

X_____ Date: _____

Minor Patient Name(s)

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