GENERAL FINANCIAL POLICIES FOR INDIVIDUALS & FAMILIES

Our primary concern is the dental health of our patients. Sky Dental will provide necessary dental care based on our patients' dental needs, and not a patient's insurance coverage. Should your coverage be less than anticipated, you will be responsible for any remaining obligation. We are also very sensitive about our patient's financial circumstances; however, we must structure our financial policies around sound business practices. Your understanding of our financial policy is an essential element of your care and treatment.

Please read and initial each line below.

_____ Payment is due in full when services are rendered. For your convenience, we accept all credit cards, debit cards, and cash. Third-Party financing is available through CareCredit.

_____ We offer dental insurance billing as a courtesy to our patients. You, the financially responsible party, agree that you are responsible for any and all charges for services rendered should your insurance company fail to pay any portion of the claim(s) we submit on your behalf.

_____ If you have dental insurance, we require your estimated portion of your fee at or before the time services are to be rendered. We will file a claim with your insurance company and you will be billed for any balance that remains after insurance has paid. We ask that you provide us with complete and accurate insurance information.

_____ Regardless of insurance coverage and/or determination of usual and customary (UCR) rates, the patient is ultimately responsible for any and all charges for services rendered. It is your responsibility to know the benefits and limitations of your current dental coverage plan.

_____ If you are unable to keep a scheduled appointment, we require at least 24 hour notice in order to allow another patient to benefit from that time. Failure to let us know of your cancellation 24 hours in advance will result in a nominal charge of $25.00 per 30 minutes of scheduled appointment time. After a third missed appointment you will be put on a day-of call system which is when the patient calls the office the day of availability to check for any open appointments. This system was implemented to limit the amount of last minute cancellations/no-shows due to the high demand for dental care.

_____You, the financially responsible party, agree to pay for any collection fees, including legal or other services, necessary to collect overdue accounts. There will also be a $50.00 charge for any returned check. Balances greater than 90 days past due will incur interest charges. Also, accounts turned over to collections will incur all fees associated with the collection agency and may also result in you being dismissed from Sky Dental.

_____ There is a $35 fee to copy patient records, unless we are copying them for a specialist referral we have arranged. There is also a fee associated with duplicating x-rays. We appreciate you taking the time to read this policy statement.

We are pleased to welcome you and your family to our practice and thank you for choosing us for your dental needs!

I, _____, have read and understand the Patient Financial Policy for Sky Dental.
(print name)

Signed _____SIGN HERE Date: _____