Financial & Insurance Policies

Patient Name_____

Person Responsible for Account_____

Relationship: (Circle One)

Patient Guardian Spouse Father Mother

Payments

Payment is due at the time services are rendered. For patients with dental insurance, you will be expected to pay your estimated portion at the time services are rendered. For your convenience, we accept cash, personal check, debit cards, and all major credit cards (Visa, MasterCard, AMEX and Discover). We also offer flexible finance plans through Care Credit. These plans can fit a wide variety of patient financial needs. **If you are unable to keep an appointment, kindly give 2 business days notice to avoid a broken fee.**

Dental Insurance

Your insurance plan is an agreement between **you and you insurance company**. If your insurance changes, please notify us prior to your appointment. We file claims to your insurance company as a courtesy to you. Our office has no financial relationship with your insurance carrier; therefore you are responsible for bill. After 30 days, we ask that you call your insurance company if no payment has been received. After 60 days, any outstanding insurance will be your responsibility. Also please understand, you are responsible for your charges incurred regardless of your insurance payment. **Treatment is based on what your dental needs are and not on what your insurance company will or will not pay.**

In order for us to file your insurance, **you must:**

1. Provide us with your current and correct insurance information.
2. Assist in following up with your insurance carrier if there is a problem with the payment of your claim, Please remember, ultimately you are responsible for your entire account but we are happy to assist you.

Billing

Please inform of us of any financial concerns so an agreement can be made up front of how the account will be paid. Please understand once an account is turned over to collections, it cannot be called back.

Authorization

I hereby authorize payment of insurance benefits directly to Southeast Family Dental, otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment not covered by dental insurance. I authorize Southeast Family Dental to administer such medications and perform diagnostic/photographic procedures as may be necessary for proper dental care. The information on this page and the dental/medical history are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical records to other dental professionals if I am referred out for further treatment.

_____ _____

Patient/Responsible Party Signature Date