OUR FINANCIAL POLICY

Please read carefully and sign.

- **FULL PAYMENT IS DUE AND PAYABLE AT THE TIME OF SERVICE.**
- We accept **CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, and CARECREDIT** (no fee, no-interest health care financing program). Any special arrangements must be discussed with and approved by our billing manager **prior** to the start of treatment.
- **For patients covered by insurance**, we will gladly submit your insurance claims for you. Estimated deductibles and co-pays are due and payable at the time of service. We do not, however, submit for reimbursement from Flex Spending Accounts (FSA) or Health Savings Accounts (HSA); you are responsible for paying our office for the service and submitting your own reimbursement claims.
- **For minor patients**, the adult accompanying the minor to the appointment is responsible for full payment at the time of service.
- **All balances on billing statements are due and payable upon receipt.** You are responsible for all fees for treatment rendered regardless of your status as an active or inactive patient in the practice.
- The **fee for a returned check is $25** and is non-refundable. We reserve the right to refuse payment by check thereafter.
- **Delinquent accounts:** Patients with delinquent accounts will be required to make full payment on the account prior to making appointments for additional treatment. A **late fee of $25** will be applied to all accounts overdue more than 60 days from the date of service. **INTEREST at the rate of 1-1/2% per month** will be applied to such accounts. You are responsible for costs associated with the collection of a delinquent account including reasonable attorney fees and court costs. Dr. Stebbins is authorized to disclose portions of the patient's dental record to the extent necessary to determine liability for payment and to obtain reimbursement. Furthermore, you may be dismissed from the practice.
- **Cancellations/Missed Appointments:** We require 24 hours advance notice for cancellations. **We do not accept cancellations via our voice mail or e-mail system. You must speak with a staff member or, after hours, contact Dr. Stebbins at the number given on our answering machine.** Last minute cancellations or missed appointments will be recorded in the patient chart and will result in a **$50 broken appointment charge** to your account. Patients with frequent broken appointments may be dismissed from the practice.

Insurance

It is our pleasure to assist you in maximizing your insurance benefits and, as a courtesy, we will file your claims for you. We will estimate your deductible and the portion not covered by your insurance, and this amount is due and payable at the time of service. As it is impossible for us to know the details of every insurance policy, our estimate may differ from the actual coverage, and your account will be adjusted accordingly when your claim is paid. Our practice is committed to providing the best treatment for our patients and we set our fees based on the quality of treatment we provide. The insurance policy is a contract between you and the insurance company. You are ultimately responsible for the fees on the account regardless of insurance coverage. Insurance is not a substitute for payment.

Furthermore:

- You must provide our office with complete and accurate billing information prior to treatment, including current insurance card. If we cannot verify your insurance, you will be asked to make full payment.
- You must know and understand the terms of your the insurance coverage. If you have questions, please ask us.
- You are responsible to David R. Stebbins, D.M.D. for all charges for dental treatment not covered by insurance, including co-payments, deductibles and fees for non-covered services. You are responsible for **all** fees not paid after 60 days from date of service, regardless of the status of your insurance claim. If claim is subsequently paid, you will be refunded the claim amount.
- You authorize David R. Stebbins, D.M.D. to submit claims and you assign insurance benefits to Dr. Stebbins including any or all insurance checks that are sent directly to you. Assignment will remain in effect until revoked in writing. A photocopy of this assignment is considered as valid as an original.

If you have any questions about our financial policy or have any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask.

I have read and understand the above policy and agree to comply with its terms.

Signed (patient or guarantor):_____Date:_____

Print Name: _____

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