HOPEWELL FAMILY DENTAL

FINANCIAL AND INSURANCE POLICY

Our goal is to provide the highest quality of dental care possible and to clearly communicate our financial policy.

I, _____ agree to be responsible for payment of all services rendered to myself and my dependents. I understand any treatment fee will be honored up to 90 days from the date of examination. I understand, to collect any debt, my credit history may be checked through use of my Social Security number and any other information given.

I understand that there is a $25 monthly late fee if I do not pay my balance within 30 days of a statement due date, unless specific arrangements with the office have been made. There is a $35 processing charge for insufficient funds or returned checks. I agree that in the event my account becomes delinquent due to non-payment and is turned over to an outside collection attorney or agent, I agree to pay all actual and reasonable fees, legal fees, costs, expenses, and court costs incurred to collect payments due.

I grant my permission to this office to phone or email me to discuss my account, appointments, or treatment.

As a courtesy to me, I understand this office will file any dental insurance claims on my behalf. I hereby authorize release of all information needed for such claims and authorize my insurance company to pay directly to this office benefits accruing under my policy. If the insurance company does not pay after 60 days, I agree to pay the full remaining balance.

I understand this office will always do the best to help me maximize my dental benefits; however, ultimate responsibility for payment is mine, and I am obligated and agree to pay this office in accordance with its credit terms and policy.

☐ **I have read the above conditions of treatment and payment and agree to these terms.**

☐ **I do not agree to the terms above and/or do not want to disclose my SSN.** I realize this is my choice and I can still receive treatment here. I do understand this comes with the following changes: (1) all treatment will need to be paid in full at time of service, (2) insurance will reimburse me and not my dentist, (3) I must pay with credit, check, or cash, (4) no payment arrangements will be possible, and (5) often insurance cannot be verified and estimates will be less accurate.

_____ _____

Patient/Parent/Guardian Signature (Responsible Party) Date

_____

Relationship to Patient