

# **James Center Dental Excellence**

## **Financial Policy and Agreement**

### **Outstanding Patient Service is Our Goal**

The goal of James Center Dental Excellence is to make sure that you receive the highest quality dental care and service. One step is to make certain that our financial policies are clear and understood by you.

### **Insurance – We go the Extra Mile**

If you have insurance, we will make a good faith estimate of your benefits and defer billing you for that amount for up to 60 days. We will take complete care of completing and filing the appropriate claim forms with your insurance company. We will also track your claim and make sure that it is paid in a timely manner. We will follow-up with your insurer when claims are not processed efficiently and attempt to expedite payment. We are also happy to provide your insurance company x-rays or other information they may require.

If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. **Although we will make every effort to help you obtain your benefits, we cannot force your insurer to pay.**

### **Your Payment is Due at the Time of Treatment**

Fees for treatment are due at the time of treatment after deduction of your good faith estimate of insurance benefits as described above.

### **Payment Options:**

Cash Check, Visa MasterCard , Discover, American Express, Care Credit

### **Patient Responsibility**

I acknowledge my responsibility for payment of the services received from James Center Dental Excellence in accordance with James Center Dental Excellence's regular fees and terms. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or any of the charges.

I understand that this account becomes delinquent if not paid within 60 days after billing and that at that time a Finance Charge of 1.0% of the unpaid balance will be charged every month until balance is paid in full.

### **Assignment and Release**

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier.

Patient Signature: \_\_\_\_\_

Date \_\_\_\_\_

Staff Member Initials \_\_\_\_\_ Date: \_\_\_\_\_