**SHOREVIEW DENTAL FINANCIAL POLICY**

Thank you for choosing us for your dental care. We are committed to providing you excellent care, and payment of your bill is part of successful treatment. Our financial policy is based on open and honest discussion of our fees.

* **FINANCIAL POLICY**

Payment is due at the time of treatment, unless other arrangements are made prior. Payment or services of the treatment of minors is the responsibility of the adult accompanying the minor.

* **INSURANCE**

As a service to our patients, we will bill your insurance company directly to help maximized your benefits.

I, the undersigned, have insurance with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name of insurance company)

 and assign directly to **SHOREVIEW DENTAL** all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid for by the insurance. I hereby authorize SHOREVIEW DENTAL to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

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 Date Signature of patient / parent

* **USUAL & CUSTOMARY RATES**

Our fees reflect our commitment to the quality our patients deserve and are considered usual and customary for the area, **regardless of any insurance company’s determination**

* **SERVICE CHARGES**

All accounts that are over 60 days past due(regardless of insurance claim status) will be charged an interest rate of 10% per month

* **COLLECTION FEES**

Fees incurred to collect payment will be billed to, and payable by the patient/parent.

* **CANCELLATION/RESCHEDULE FEE**

Any patient who fails to show or cancels/reschedules an appointment without 24 business hours

(NOT including weekends/holidays) notice will be charged a $50.00 fee

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 Date Signature of patient / parent