FINANCIAL POLICY

Thank you for choosing Fox River Dental as your dental provider. We look forward to building a lasting relationship focused on keeping your smile bright and healthy. The following is a statement of our financial policy which we require you to read and sign prior to your treatment. We're happy to help with any questions you may have.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE (CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED AMOUNTS). WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND CARE CREDIT.

INSURANCE

1. **Deductibles, co-payments and non-covered amounts (including fees above your insurance company's usual and customary fee schedule) are due at the time of service.**
2. **We must have the correct insurance information in order for us to bill your insurance company.**
3. We file claims to your insurance as a courtesy to you. It's ultimately your responsibility to know and understand your dental insurance, for example: Coverages, Maximums, and Frequencies; including Deductibles.
4. All estimates quoted are based upon information provided to us by your insurance company and are **estimates only and not a guarantee of payment.**
5. **If your insurance company has not paid your account within 60 days, the balance becomes your responsibility.** Insurance companies are required by law to pay or deny claims within 30 days.
6. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary by your insurance company.
7. Our first and only priority is our patients and the quality of care.
8. Please remember, the insurance contract is between you, your employer, and the insurance company. We file claims to your insurance company as a courtesy to you.

_____ **Please initial here** that you have read and understand the above insurance information (all 8 lines).

PAYMENT

1. **Payment is due at the time services are rendered.**
2. We accept cash, personal checks, all major credit cards/debit cards.
3. We also offer payment plans through Care Credit. (Financing your treatment will allow you to begin your treatment immediately before situations potentially worsen and become more costly.)
4. All returned checks are subject to a $35 return check fee.
5. Any unpaid balance over 30 days will be subject to monthly interest of 1.5% (APR 18%).

6. If payment is delinquent by 90 days it will be referred out for collection and the patient is responsible for any fees associated with collections.
7. We realize at times difficulties do occur, if this happens please call our office to discuss the situation with our financial manager.

_____ **Please initial here** that you have read and understand the above payment information (all 7 lines).

CANCELLATIONS

1. It is the philosophy of our office to provide optimum patient care.
2. All patients are seen by appointment only and are scheduled with your individual needs in mind. This allows us to focus our efforts on caring and treating our patients to the best of our abilities.
3. **When a patient does not show up for their appointment or cancels too close to their scheduled time, we are not able to fill this appointment with another patient who desperately needs dental care**.
4. In addition, if a patient shows up 10 or more minutes late to an appointment, we fall behind and other patients have to wait.
5. This policy is our attempt to ensure that all patients receive dental care in a timely manner.
6. **If you need to cancel your appointment, we ask that you call us at least 48 hours before your appointment time.**
7. **A minimum $50.00 cancellation fee will be placed on your account for any no show appointments or cancelled/rescheduled appointments with less than 48 <u>business hours</u> notice.**
8. We reserve the right to charge a cancellation fee as follows: **$50.00 for scheduled appointments under 60 minutes, $90.00 for 60-90 minute scheduled appointments.**
9. We realize that true emergencies do occur and we will be flexible under those circumstances.

_____ **Please initial here** that you have read and understand the above cancellation information (all 9 lines).

I have read the above and understand and agree to these terms.

_____

Patient name printed Date

_____

Patient Signature Date