Park East Dental

Statement of Financial Policy

Thank you for choosing us as your dental health care provider. We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our statement of Financial Policy, which we require our patients to read, understand, and sign prior to any treatment or care.

In order for us to successfully bill your insurance company, we need complete information and we require a copy of your insurance card at each visit.

Methods of payment:
We accept Cash, Checks, Visa, Discover, American Express, and MasterCard. We offer payment plans for large cases and will be happy to discuss this option with you **prior** to treatment.

When Payment is Due:
Payment is due at the time that services are rendered in our office unless prior arrangements have been made.

About your Insurance Coverage:
Your insurance policy is a contract between you and your insurance company. Since we are not a party to that contract, your account balance is your responsibility in all cases, whether your insurance pays or not. As a courtesy to you, we will file a claim on your behalf with the insurance information that you have provided us. However, if your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and you will need to follow–up with your insurance directly.

About our staff:
Our staff has been trained to understand many insurance company policies, but they DO NOT have all the answers to your particular plan. Please see your benefit book or call your insurance company directly for any specific questions.

Past Due Account Balances:
If your account becomes past due, appropriate action will be taken to collect the amount due. In addition to a 1% service charge per month that your account will be charged when past due, should this account need to be turned over to a collection agency, you will be responsible for any and all collection and/or attorney fees incurred by us in the collection of this account.
The fee for all checks returned for insufficient funds is $25.00. This fee will be charged to your account when your check is returned from the bank.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY
I UNDERSTAND AND AGREE TO THE POLICY

Account Guarantor's name:_____ **Date** _____

Signature of Guarantor:_____ **Date** _____