FINANCIAL POLICY

We at the office of Dr. Allan are proud to be part of a team whose primary mission is to deliver some of the finest and most comprehensive dental services available today. And to have a fun time doing it! We are concerned about your dental care and want to insure that it is performed in a responsible manner.

Financing your treatment allows you to start your dental care immediately while selecting a payment option that works best for you. Most importantly, it allows you to enjoy the benefits of dental treatment without financial strain on you.

Again, we are here working to provide excellent dental work for you, but we are also working to provide for our families.

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED UNLESS PRIOR FINANCIAL ARRANGEMENTS HAVE BEEN MADE.

I. PAYMENT OPTIONS:

1. **Cash:** This includes money orders and personal checks.* A 10% discount is made for all **non-insurance** related "in-full payments". Please note: as a general rule we cannot accept post-dated checks.
2. **MasterCard/Visa/American Express/Discover:** We accept credit cards as payment for dentistry as your limit allows. A 5% discount for "in-full payments" is extended. Again, for **non-insurance** related charges only.
3. **Deposit:** Where extensive treatment is planned, a deposit may be required prior to scheduling the appointment. Any deposits paid are applied to the treatment balance.
4. **Emergency treatment:** Must be paid in full at the time of service.

II. INSURANCE:

If you have insurance we will help you estimate the coverage you have available. As a courtesy we will bill your insurance plan.

Professional care is provided to you, our patient, and not to your insurance company. Thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. **All unpaid balances are your responsibility.**

III. BROKEN APPOINTMENTS:

We all dislike being stood up. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice. Our policy is to charge $25 for all broken or "no-show" appointments.

IV. COLLECTIONS:

In an effort to reduce billing costs, this office is on a time activated computerized system. Accounts with outstanding balances over 60 days past due are automatically transmitted to a service company for billing assistance.

The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing fifty percent (50%) of the principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing.

V. SIGNATURE:

YOUR SIGNATURE MEANS **THAT YOU ARE THE FINANCIALLY RESPONSIBLE PERSON. I HEREBY AUTHORIZE DR. ALLAN TO RELEASE ANY AND ALL MEDICAL INFORMATION (INCLUDING DENTAL INFORMATION) TO THE INSURANCE CARRIER. I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR. ALLAN OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.**

I HAVE READ AND UNDERSTOOD THE TERMS OF THIS FINANCIAL POLICY AND AGREE TO THOSE TERMS. I PROMISE TO PAY FOR ALL CHARGES INCURED DURING THE COURSE OF PROVIDING DENTAL TREATMENT. THIS AUTHORIZATION REMAINS VALID AND EFFECTIVE FROM THE DATE OF SIGNING UNTIL REVOKED IN WRITING.

Signature of authorized person _____Date _____

Rev. 8/04

** Due to our bank's policy on handling returned checks and the accounting charge incurred, it is necessary for us to have a $20.00 returned check charge.
Thank you for your understanding.
^ "In-full payment" means payment for all services completed the day of the appointment.