Mary E. Fiedler, D.D.S.
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Agreement of Financial Responsibility

Thank you for choosing us as your dental health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance.
- Our office understands the value of insurance to our patients and we willingly accept assignment of insurance benefits. It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, co-payment percentages, annual deductible, annual maximum, any non-covered services, and any pre-authorization requirements.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will collect your estimated co-payment and applicable deductible when services are rendered. Next, we will bill your insurance company, and then bill you for any additional amount determined to be your responsibility based on your policy's explanation of benefits (EOB). This process generally takes 30-45 days from the date of services rendered.
- Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

I have read the financial policies listed above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

______________________________ ____________________
Signature of Patient/ Responsible Party Date

______________________________ ____________________
Name of Patient/ Responsible Party (Print) Relationship to Patient