Mary M. Fisher, DDS
General & Cosmetic Dentistry

Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is a statement of our Financial Policy. Please understand that payment of your bill is considered a part of your treatment. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask the front office before your appointment.

We ask that all patients read, sign and date our Financial Policy, as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS and CARE CREDIT. We bill your insurance as a courtesy to you. You must understand that:

1. Your insurance company is a contract between you, your employer and the insurance company. We are NOT a party to that contract. In general, our relationship is with you, NOT your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit and some insurance companies arbitrarily select certain services they will not cover.
3. In the event we do accept assignment of benefits we require that you be pre-approved on our extended payment plan or provide a credit card with authorization to bill your account for the remaining balance.
4. Our fees are considered usual, customary and reasonable by most insurance companies and, therefore, provide reimbursement to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse on an arbitrary schedule of fees.
5. If your insurance carrier has not paid on a claim within forty five (45) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance.
6. Returned checks and balances older than ninety (90) days may be turned over to our attorney and collection agency. Additional collection fees of up to 50% will be applied to your account.

PLEASE NOTE that unless cancelled at least 24 hours in advance, you will be charged $50.00 per hour of appointment time scheduled for any missed appointments. Please call as soon as possible if you have to reschedule your appointment.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account. We offer payment plans for situations where temporary financial problems may interrupt regularly scheduled payments.

I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my dental insurance benefits to Mary M. Fisher D.D.S. I also authorize to release any protected health information required to secure payment. I have received, read and understand the Notice of Privacy Practices.

Patient Signature: ______________________________________ **Date:** ____________________