

Bayshore Dentistry

FINANCIAL POLICY

Dear Patient,

Thank you for choosing us as your Dental Health Care providers. The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore and your dental health. If you have any questions or concerns about our payment policies, please do not hesitate to ask our business staff. We ask that all patients read and sign our Financial Policy before you are seen by our Dr.

Payment for services is due at the time services are rendered. We accept cash, checks, debt, and most credit cards. We will be happy to help you process your insurance claim for your reimbursement if you provide complete insurance information. However, you must understand that:

1. Emergency visits or treatment for patients "not of record", for patients who have been out of the practice for over one year, or for patients who have an existing balance or bad credit with our office, will be asked for payment at appointment reservation.
 2. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We will file, at no charge to you, one pre-treatment estimate to determine your level of benefits - what your insurance will pay.
 3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. The reasonable and customary fee limits are determined by premium levels, regional averages, and your plan purchaser's decision on reimbursement levels.
 4. Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment.
 5. We require you to pay any balance your insurance has not paid within 45 days.
 6. If you are covered by a PPO or HMO or other managed care company that requires your treatment, be performed by a "participating provider", it is your responsibility to notify us about this. Our office participates in some plans and not others. Please understand that if we do not participate with your insurance
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plan, you are responsible for full payment of your dental fees. If we do participate with your plan, you are responsible for unpaid deductibles and co-payments that are due.

7. When you make a restorative appointment, you may be asked to pay a deposit. The deposit will be applied to your dental treatment. Because insurance coverage varies greatly and is just an estimate you may have a balance on your account after your insurance makes payment to us, despite the deposit that you paid. Please understand that you are responsible for any balance that is due after your insurance pays.

Please note that if you don't cancel or reschedule your appointment 24 hours in advance you will be charged for a broken appointment. This including prophylaxis (dental cleanings), at an hourly rate for the time you scheduled. Please call if you must reschedule.

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.

Again, thank you for choosing us as your health care providers. We appreciate the opportunity to serve you.

With my signature, I hereby certify that I am an adult 18 years or older, and I am the responsible financial party for dental services rendered by Dr. Chacknes.

PATIENT SIGNATURE

DATE