



Financial Policy

Insurance Facts:

We are pleased that you have a dental insurance policy. We will do everything we can to help maximize your benefits on a yearly basis. We ask that you understand that we neither work for the insurance companies, nor do we wish to. We work 100% for YOU. We will bill your insurance company as a courtesy to you. Your insurance company makes the final determination of your eligibility by the policy your employer has contracted with them. However, it is required that your estimated portion be paid at the time services are rendered.

Our office does not diagnose, render treatment, or establish fees according to any insurance tables or allowances. Office fees are based on care, skill and judgment of the professionals delivering the services, and by the cost of operating a dental office dedicated to excellence. Most importantly, remember that we work 100% for YOU, not the insurance company.

Monthly Statements:

If you have a balance on your account, we will send you a statement. The balance on your statement is due and payable when the statement is issued. It is considered past due if not paid by the end of the month, unless other arrangements are approved in writing.

Financial Options:

We accept Visa, MasterCard, Discover, & American Express. We have a partnership with CareCredit that offers extended payment options of 6 and 12 months interest free, or 14.99% interest on payment plans from 24 to 60 months.

Charges to Account:

We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid in full at the time of service. If your account becomes past due, we will take the steps necessary to collect this debt.

There is a \$30 fee for any checks returned by the bank.

I understand that I am ultimately responsible for all charges for dental services and materials, regardless of my dental benefit plan. To the extent permitted under applicable law, I authorize the release of any information to my insurance company relating to my insurance claims. In addition, I authorize payment of dental benefits to be paid directly to Rogers Dental Center, P.A.

I have been provided with a copy of this agreement.

Patient Signature _____ **Date** _____
Patient or guardian