

Azalea City Dental Financial Policies

Treatment Fees

- The total treatment fee is based on the difficulty of the case and your desire for either comprehensive treatment or limited problem-focused care. Treatment fees assume that you will complete treatment in a timely manner. Any untreated oral disease may worsen from the time of the original examination. Oral disease that worsens may require a change in the treatment fee and new financial arrangements.
- Treatment fees also assume that you will make all scheduled appointments. In order that you may receive the best care possible, our doctors schedule specific quality time with you. They expect you to honor that scheduled appointment.
- **If you fail to appear for an appointment for any reason, or if you cancel or reschedule an appointment with less than 24 business hours' notice to our office, you will be assessed a \$50.00 fee per scheduled hour.**
- All fees quoted prior to treatment are estimates. Treatment plans may change from time to time causing a change in the actual costs. In the rare event that treatment changes, causing an increase in treatment fees, we will notify you of the change. Refunds will be given only if you pay for a procedure, and it is thereafter determined that you will not have that procedure performed in our office.

Insurance

- You are responsible for knowing about and understanding your own insurance and what it will or will not cover.
- If you are using insurance to pay for part or all of your treatment, you understand and agree that we have no control over insurance coverage. We will, however, do everything in our power to give you an accurate estimate. You must assume that the expenses we quote are the minimum amount that you will owe. If your insurance does not pay as much as we estimated, you may owe the balance.
- **If you are using insurance to pay for part or all of your treatment, you are still responsible for the entire bill. If the insurance company mails you the check, do not cash it. Bring it in to our office to apply that amount to your bill.**
- Insurance companies often delay payment for any number of reasons. If your insurance company fails to submit payment within 30 days of when we submit the claim, your account will be charged interest on the amount expected from your insurance company. This fee will apply regardless of the insurance company's reason for delaying payment. If you do not want to pay this interest charge, you may pay your entire bill, and we will issue a refund to you when your insurance company pays. Your refund will equal the amount that the insurance company pays our office. We encourage this option as it usually qualifies you for an additional 5% discount on the total cost of your treatment plan. This option is for treatment plans over \$2500.00.

Payments

We will work with you to determine the best way to incorporate your dental expenses into your family budget. All of our payment plans are based on the fact that payment is due the day service is rendered, by cash or check. Any payment schedule that is established does not necessarily correspond to your appointments. Some payment plans may be monthly, yet you may have multiple appointments or you may have no appointments in a given month. You authorize Azalea City Dental to request credit score information in order to assist in any financing necessary for dental care for you or your family.

- **Returned Check Fee for checks that are returned due to Non-Sufficient Funds (NSF), Closed Checking Account, or Stop Payment:** There is a \$30.00 fee for each check returned for these or any other reasons. If two checks are returned for non-payment, we will require all remaining payments to be made with cash, certified funds, or by debit or credit card.
- **Delinquent Accounts:** Our Financial Coordinators are always available to assist you. If you encounter a financial problem that makes it difficult to pay as agreed, please call our office to schedule a financial consultation. If it becomes necessary for us to use a third party to collect your unpaid account, you will be held responsible for any legal fees and costs incurred in collecting your account.

By signing below, you hereby acknowledge that you have read and understand these Financial Policies. Signing this document does not mean that you are entering into any contract for dental services with Azalea City Dental.

Print Patient Name _____

Date: _____

Print Legal Guardian Name (if applicable) _____

Patient/Legal Guardian Signature _____

Financial Coordinator Signature _____