PLEASE READ OVER COPY

WILLIAM E. POOLE
FAMILY DENTISTRY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout your treatment. We encourage you to ask questions and to get involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment.

FINANCIAL AGREEMENT:

Patients are expected to pay for services at the time they are rendered, unless prior arrangements have been made. Our patients who have dental insurance are expected to pay the amount of their deductible and any procedures not covered by your insurance at the time of service. We accept the following forms of payment: Cash, Check, Visa/Mastercard, Discover, American Express and Care Credit.

For ALL crown, crown and bridge and partial appointments, a $200.00 deposit is required at the initial appointment.

For our patients with no dental insurance, a 5% courtesy will be applied for check or cash payment at the time of service.
Checks that are returned to our office for insufficient funds are subject to a $35.00 returned check fee.

INSURANCE INFORMATION:

As a courtesy, we will submit claims to your insurance company. Your insurance plan may not cover 100% of the cost of your treatment. If insurance has not paid within 45 days of treatment, you may be ask to make full payment to this office and be reimbursed when your insurance company pays. All insurance estimates are still the patient's responsibility.
You have the option to ask for a pre-authorization for dental procedures. This process can take up to 6 weeks and it is still not a guarantee of payment.

The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. Any money owed for services that are denied due to exhausted benefits is still the patient's responsibility.

If you have any questions about your insurance plan, please contact them directly.

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Your complete insurance information must be presented at the time of service.

We do participate with the following insurance companies:

1. Delta Dental Premier
2. Assurant
3. Met Life

All accounts that remain outstanding for more than 90 days will be sent to a collection agency and all fees will be added to your account.

Patient agrees to be responsible for all costs of collection on unpaid balances including, but not limited to, 1.5% interest (18% annually), collection fees (up to 50%), court costs and reasonable attorney fees.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect payment of your account. If such problems do arise, we encourage you to contact us promptly.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy, I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: _____ (Seal)

Date: _____

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