Financial Policy

Payment

Payment is expected at the time of service unless other arrangements are made. We will be happy to file an insurance claim on your behalf but please understand that any lack of payment from your insurance company will result in your responsibility to arrange payment directly with us. We are willing to work with you but you must inform us if you need assistance. Accurate, up-to-date information, including phone numbers, mailing address and insurance information (if applicable) is the patient's responsibility to keep Southwest Family Dentistry informed.

Your Dental Benefits

Your dental benefit plan is an agreement between you and your place of employment. Our office will accept assignment of benefits from your dental benefit company and will be happy to assist you in understanding of your benefits. However, we consider you to be responsible for the payment of your dental care and not your insurance benefit carrier. Dental benefit programs are designed to assist you in payment for dental work. Your benefit plan may or may not pay on some dental procedures. It is important that you take time to read your dental benefit manual to become familiar with what is covered, any waiting periods, and exclusions. Our office will submit all charges to your insurance carrier and will assist you should problems arise with payment.

Pre-Estimation of Benefits

As a service to you, we will be happy to submit your proposed dental treatment to your insurance carrier for a pre-determination of benefits. The pre-determination of benefits does not guarantee payment. Again, you are responsible for payment of your account. Pre-determination of benefits is a service we provide to you at no charge. Benefit carriers typically honor pre-estimates for 60-90 days.

Written Treatment Plans

We will provide you with a written treatment plan and disclosure of all costs associated with your treatment. On occasion, circumstances present which may alter what has been planned and the cost. We will immediately inform you of any changes to your treatment and cost should they occur during the course of treatment. We will proceed only after you have agreed to the change in treatment.

Finance Charge

I hereby agree that I am financially responsible for all charges, whether or not paid by insurance. I agree that I am also financially responsible for any and all late fees, interest, or re-billing fees. If my account is turned to collection for non payment, I agree to pay any and all court costs if litigation is required to obtain payment. I understand that I will be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 60 days. My signature certifies that I have read and understand the terms of this agreement as indicated above.

____

Signature **Date**