Financial Policy

As we enter this doctor-patient relationship, we agree to provide quality dental care at a fair and reasonable price, and you in turn, agree it is your obligation to be prepared to **pay at the time of service** and to understand the benefits of **your insurance**. We want to explain our financial policy to you so there are no unpleasant surprises.

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept cash, check, Visa, Master Card and Discover. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due at the time services are provided. Any remaining balance after your dental plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to appointment, the account will be notated as private pay and payment will be due in full. *Account balances over 90 days with no payment will be reported to the credit bureau(s).* INITIALS_____

- **Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays 100%. It is your responsibility to know what your policy covers and what it does not.** Any item deemed "not-covered" by your insurance carrier will be your financial responsibility. Any disputes about payment must be resolved between you and your insurer. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. INITIALS_____

- As a courtesy to you, we will file primary participating insurance for you with proper assignment. Any additional insurance policies will be yours to file with receipt from our office. Please bring your primary insurance card with you to every visit. I understand all remaining balances are my responsibility to satisfy, prior to additional services being rendered. INITIALS_____

- This office is not party to legal disputes. The financial responsibility rests with the patient or parent/guardian for patients under 18 years of age. INITIALS_____

- A $100 fee will be assessed for all returned checks. INITIALS_____

- Payments and credits are applied to the oldest balance first, except for insurance payments which are applied to the corresponding dates of service. Refunds over $50 will be provided after all outstanding claims are satisfied. Credit balances less than $50 will be available and processed upon request of the patient. INITIALS_____

ASSIGNMENT OF BENEFITS:

I request payment of dental benefits, otherwise payable to me, directly to Mark A. Porter, D.D.S., P.A. for services provided by him.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

Responsible Party Signature: _____ Date: _____