Office Financial Policy

We are committed to providing you with the best possible dental care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

If we do not have a contractual agreement with your insurance company, a partial payment for office services is due at the time services are rendered. We accept cash, checks, and credit card payments. We will then file the insurance claim.

Returned checks are subject to applicable bank fees of not less than $25.00. A delinquent billing charge of $25.00 plus interest at the rate of 1.5% per month will be assessed to all account balances that have not made payment arrangements with us.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance.

You MUST realize, however, that:

1. Our fees are generally considered to fall within the acceptable range by most insurance companies and, therefore, are covered up to the maximum allowance determined by each carrier. Thus, our fees are considered to be the usual and customary by most companies.
2. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will cover.
3. All co-payments are to be made at the time of service.
4. You are responsible for informing us of any changes in your insurance plan or policy. Failure to do so may result in denial of coverage, the fees for which you will be held responsible.
5. Please note that deductibles, co-insurance and co-pays are the RESPONSIBILITY of the patient/policyholder.
6. WE DO NOT BILL THIRD PARTIES. Any court order between parents is a civil suit. The parent who brings the child is responsible for the charges.

We must emphasize that, as dental care providers, we are dedicated to providing the best treatment to our patients. We will do our best in the filing of insurance claims; however, all charges are your responsibility from the date services are rendered.

Thank you for your understanding of our Office Financial Policy. If you have any questions, PLEASE do not hesitate to ask.

I HAVE READ THE OFFICE FINANCIAL POLICY OF GEORGETOWN NORHT DENTAL GROUP. I UNDERSTAND AND AGREE TO THIS POLICY AND HAVE HAD ALL MY QUESTIONS ANSWERED.

Signature of Patient (Guardian): ____

Date: _______________