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HUTCHENS FAMILY DENTISTRY

TREATMENT & FINANCIAL POLICY

Patient Name:_____ Date of Birth: _____

The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any care.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Both in-house and outside financing options are available upon request and approval. Additional fees will be applied for returned checks. All account balances over 90 days are subject to a $35.00 late fee, or may be sent to collections.

INSURANCE INFORMATION

- As a courtesy to you, we will help you process your dental insurance claims, whether your plan is in- or out-of-network. We will provide an insurance estimate to you, however, it is not a guarantee that the insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums that are your responsibility. Please contact your insurance company for a detail of your benefits. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship priority is with you, not with your insurance company. If your insurance policy is out-of-network with us, it is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. If in-network, you are responsible for any deductible, co-payment and co-insurance at the time of service. If you are out-of-network, you are responsible for payment at the time of service regardless of any out-of-network insurance company's arbitrary determination of customary rates.
- We ask that you sign this form and any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. You authorize the release of any information concerning your (or your child's) treatment for the purpose of evaluating and administering claims for insurance benefits.
- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, or card at the time we provide the service to you.
- Insurance payments are ordinarily received within 30 to 60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. For unaccompanied minors, treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

MISSED APPOINTMENTS & CANCELLATIONS

Our goal is to provide quality treatment in a timely manner with as few visits as necessary. In order to provide the best services to all our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments. Multiple failed appointments may result in being dismissed from the practice.

CONSENT & AUTHORIZATION

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my child is mine, due and payable at the time services are rendered.

By signing below, you are authorizing us to call you at any number you provide for any lawful purpose. You agree that we may place such calls using an automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone or other similar device. You agree that we may, for training and quality purposes, listen to and record phone conversations you have with us.

Patient / Parent / Guardian Signature: _____ **Date:** _____

Patient / Parent / Guardian Printed Name: _____