Bear Creek Family Dentistry Financial Policy and Agreement

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment.

Your patient portion must be paid at the time service is delivered. We accept cash, checks, MasterCard and Visa. In addition, we offer an excellent third party no-interest payment plan for balances over $1000. Our office staff would be happy to provide you with more detailed information on this plan if you are interested. Returned checks will be subject to an fee of $30 and outstanding balances older than 90 days may be subject to finance charges at the monthly rate of 1.5%.

Do you have dental insurance? YES__ NO__

If **NO**, please choose the payment option that will best serve you;
I would like to pay by cash or check at the time of service. __
I would like to pay by credit card at the time of service. __
I would like to apply for an extended payment plan through a third party financing company. __

If **YES**, please choose the payment option that will best serve you:

I would like to pay my estimated portion by cash or check at the time of service.__

I would like to pay my estimated portion by credit card at the time of service.__

I would like to apply for an extended payment plan through a third party financing company. __

If you have dental insurance, you must bring proof of insurance and we will be more than happy to submit your insurance claims for you. However, you must realize:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.

2. We cannot render services on the assumption the charges will be paid for by an insurance company. All charges are your responsibility from the date the services are rendered.

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

4. Remember, please update our office staff regarding any changes to your dental insurance policy, so that we may process your claim in a timely manner.

Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, owing to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. Your estimated patient portion must be paid at the time service is delivered. As a service to our patients, we will bill your insurance company for service, and allow 45 days for them to render payment. After 60 days, you are responsible for the entire balance and it will be due in full. If you have any questions, our courteous staff is always available to answer them.

Late Cancelled or Missed Appointments: Our office will attempt to confirm your appointments with you, and we do understand that with busy schedules appointments can be forgotten, but as a courtesy to other patients and staff it is the responsibility of the patient to remember and keep all scheduled appointments. You may be charged a fee of $75 for all appointments cancelled without 2 business day (48hr) notice or missed appointments.

Dependent Minors: Payment for services for the treatment of minors can be made by check, cash or credit card and is the responsibility of the adult accompanying the minor. If a third party will be making payment for co-insurance and/or deductibles for the dependent minor a separate financial arrangement will be made with that third party prior to rendering services.

Name of third party: _____
Phone number: _____
Address: _____
Relationship to minor: _____

If you have any questions regarding the above information, please do not hesitate to ask us. We are here to serve your dental needs.

I have read the policies described in this form. I agree to abide by the terms outlined. I understand and accept my financial responsibilities.

Patient Name:_____
Signature of patient/responsible party:_____
Date:_____