# DICK AND MITCHELL D.D.S.
# FINANCIAL POLICY

**Patient Name: First _____ Last _____**

****We would like you to please thoroughly read each section of our financial policy****

Thank you for choosing Dick and Mitchell D.D.S. for your Dental needs. Our Mission is to provide our patients with exceptional dental care. We are also committed to having a mutually respectful relationship with each and every patient.

## BASIC POLICY

Payment in full is due at the time services are provided, **this includes co-pays, co-insurance and deductibles, please be prepared to make payment at the time of your visit.**

Any remaining balance assigned to you after the claims have been processed by your insurance company will be forwarded to you. Balance is due upon receipt of your statement. **Please be advised that, there will be a $25.00 handling fee for any returned check, patient balance over 60 days old may be subject to additional collection fee and unpaid balance over 120 days old may be turned over to a collection agency.**

In order for us to service our account or to collect any amounts you may owe, that we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers.

## MEDICAL INSURANCE COVERAGE

While we are contracted to provide services for numerous insurance companies, we will file all claims to your insurance, we are **not** in a position to be familiar with every different plan and its coverage. **PLEASE be familiar with the specific health care benefits of your dental insurance before you are seen in our office.**

If you have any questions regarding your Dental coverage, please call the customer service representative for your insurance company, they will be happy to explain your plan coverage. It is very important that you keep our office advised of all changes in your personal information including Primary Care Physician, insurance coverage, address and phone numbers.

## NON-COVERED SERVICES

You are responsible to pay charges at the time of service for any treatments or procedures provided to you by our office that are **not covered** by your insurance.

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby assign all dental benefits for any services furnished to me to Dick and Mitchell D.D.S. this assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment.

**I have read, understand and agree to the above Financial Policy of Dick and Mitchell D.D.S. for payment and professional fees.**

**Patient Signature: _____ Date: _____**
**(Patient or if minor, parent or legal guardian signature)**
**If minor, relationship: _____**