MOSAIC DENTAL

MOSAIC DENTAL FINANCIAL POLICIES

Our office policy regarding financing is as follows: As a condition of the treatment performed by the providers of the office, financial arrangements must be made in advance for the full cost of proposed treatment. The practice's vitality depends upon payment for services as rendered and it is the responsibility of the patient/patient's parent/guardian to satisfy the costs incurred in dental care. Financial arrangements on the part of each individual must be determined prior to treatment completion.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are rendered. Additionally, a discount can be extended, at the management's discretion, for payments in full with cash or money order. (Inquire for more details.)

Individuals who carry dental insurance understand that all dental services furnished are charged directly to the patient and that said patient is personally responsible for payment of all dental services provided, regardless of dental insurance reimbursement. As a customer courtesy, this office will help prepare and submit patients' insurance forms as well as assist in making collections from insurance companies. We will credit any such collections to the appropriate account. However, this dental office cannot render services on the assumption that our charges will be paid in part or in full by an insurance company. (Please understand that the amount to be paid by your particular policy is pre-determined and agreed to by your employer and the insurance company. If you have any questions about the amount the plan will pay or the treatments your plan will cover, you should refer these questions to your employer.) Additionally, there may be a deductible, a coinsurance factor, and a yearly maximum to be considered. Most policies cover what they consider a "usual and customary fee." However, the insurance company sets these fees, and they are not always the same as the fees that may be charged in this or any office. All these factors may combine to reduce the benefits you will ultimately receive. We will do our best to see that you receive your full benefits within the structure of your particular dental plan.

A service charge of $15 will be charged on all accounts for any unpaid balances exceeding **60 days from date of service**, unless previously written financial arrangements are agreed upon and satisfied. Any unpaid balance **after 90 days** will be sent to a **collection agency**. I understand that the fee estimate listed for any proposed dental care can only be extended for a period of six months from the date of diagnosis and/or examination. I further acknowledge that the proposed treatment plan can shift and/or change from the diagnosed treatment plan once treatment is begun due to unforeseen circumstances beyond the doctors' control.

A **Personal Protective Equipment (PPE) charge of $10** will be charged to all date of services rendered after March 16, 2020. This charge is to provide the appropriate protective gear for all our patients and staff.

In order to better assist you and others in need of an appointment, please cancel or reschedule your appointment 24 hours prior to your appointment. There is a **$35 fee** for any cancellations or rescheduled appointments **within 24 hours** of your appointment.

In consideration for the professional services rendered to me by the doctor, at the provider's recommendation, or at my own request, **I agree to pay the reasonable value of said services** to said doctor, or his assignee, at the time said services are rendered, or **within five (5) days of billing** if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time allotted for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to your office and/or financial coordinator to telephone me at home or at my place of business to discuss matters related to this form.
I have read the above conditions of treatment and payment and agree to their content.

Printed name of patient, parent or guardian	Date:	Relationship to Patient:
Signature of guarantor of payment/responsible party	Date:	Relationship to Patient: