

**Financial and Insurance Policy**

We are committed to providing our patients with the best care possible. We would like you to be informed of our office financial and insurance policy. Payments are expected at the time services are rendered. If you have dental insurance, we are happy to help you receive your maximum allowable benefits only for the services performed. To maintain the practice operation and to prevent potential misunderstanding, we ask patients to accept and adhere to financial arrangements regarding their dental treatment.

We accept cash, MasterCard, Visa, Discover, and American Express. In addition, we offer an excellent third party financial payment plan for balances over $600.00. Our office staff would be happy to provide you with more detailed information on this plan if you are interested. If you pay with a personal check, it would have to be approved by Telecheck before being taken as a payment, and if returned, a $35.00 bank processing fee will be applied.

If you have dental insurance, please provide us with complete insurance information, and we will help you process your insurance claim for reimbursement as a courtesy to you. We accept assignment of insurance benefits; however, please be aware of the following:

1. Your insurance is a contract between you, your insurance carrier and your employer. WE ARE NOT PARTY TO THAT CONTRACT; THEREFORE, OUR FINANCIAL RELATIONSHIP IS WITH YOU, NOT WITH YOUR INSURANCE COMPANY.
2. All changes are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
4. If the insurance company does not pay your balance in full within 60 days, we will be require you to pay the balance due with cash, MasterCard, Visa, Discover, or American Express.
5. If your insurance overpays us, we are to receive payment by such before providing you with a refund amount. Amount cannot exceed the monies you have currently paid for that service

We must emphasize that as dental care providers, our relationship is with you the patient, not your insurance. We realize that temporary financial problems may affect timely payments of your account; if such situations do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, please do not hesitate to ask us. We are here to assist you with any questions or concerns you may have.

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

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Signature of Patient/Responsible Party Date

*Edgewater Dental – 3425 Highway 6 S, Ste. 108 – Sugar Land, TX 77478 – P/ 832.532.7120 – F/ 832.532.7637*