Financial Policy and Agreement

BOND
FAMILY & IMPLANT DENTISTRY

Thank you for being a part of our practice and trusting us with your care! We hope to establish long lasting relationships with our patients and look forward to serving you for many years to come. Please read and complete this entire form.

Initial

_____ We require payment in full for your portion on the day of service. If the treatment plan is altered during your appointment, additional fees or refunds will be processed at check out. We are pleased to offer extended financing options if needed.

_____ **If you have any questions regarding your dental benefits or how your insurance company has processed your claim, please contact your insurance company directly.** *We do not allow insurance companies to dictate our treatment recommendations. Unfortunately, at times they will "disagree" with our recommendations and may deny your benefits.*

_____ We are happy to provide an estimate of your portion due considering your insurance but cannot guarantee its accuracy. At your request, we can submit a "pre-treatment authorization" to your insurance company. While this delays treatment, it will give you a more exact out-of-pocket amount. **We always recommend you call your insurance company directly to verify coverage amounts.**

_____ As a courtesy to you, we will file a claim with your insurance company after providing treatment. We frequently must appeal a denied claim on your behalf. Please know that we are working hard for you! **Despite our best efforts, there are times when insurance claims are completely denied.** Ultimately, you are responsible for all charges incurred in our office.

_____ Occasionally, insurance benefits will be paid several months after treatment was provided, and a remaining balance will exist on your account. **You may be surprised to receive a statement showing money due for a procedure completed months ago!** We apologize if this happens to you, and we are happy to go through the details of your statement so there is no confusion.

_____ Your appointment time is reserved especially for you. We encourage all patients to keep their appointments. **If you must change your appointment, we require at least 24 hours' notice to avoid a $50/hour cancellation fee.** For future scheduling, we prioritize patients who keep their appointments. We understand emergencies do happen, these will be documented and waiving the fees will be considered on a case by case basis. Any discount applied to treatment will be voided due to late notice or no-show appointment cancellations or late payments.

I agree with the above conditions. I understand that all charges incurred in this office are my responsibility regardless of insurance coverage.

Print Name: _____Date: _____

Patient/Parent Signature: _____