LANSDOWNE
DENTISTRY
BY DESIGN

FINANCIAL POLICY

Dear Patient:

Thank you for selecting us as your dental care provider. The following information describes our Financial Policy. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask one of our front office staff members.

We ask that you read and sign our Financial Policy and complete our Patient Information Form prior to seeing your dentist

Payments for services rendered are due at time of treatment. We accept cash, personal checks, and for convenience, Visa and MasterCard. We shall help you process your insurance claim for your reimbursement as long as we have all of your insurance information. We accept assignment of insurance benefits. However, you will be required to pay the portion of the service that we estimate will not be paid by the insurance company.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to the contract. Our financial relationship is with you, not your insurance company.
2. All charges are your responsibility whether or not your insurance company pays. 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 deductible and co-payments, are due at time of treatment.
4. If the insurance company does not pay your balance within 30 days, we will ask that you contact the carrier to assist with payment in a timely fashion.
5. If the insurance company does not pay in full within 90 days, we will require you to pay the balance due with cash, personal check, MasterCard, or Visa.
6. Balance older than 60 days will be subject to interest charges of 1.5% per month. Returned checks will have an additional fee of $28 added to the amount of the returned check.
7. If it becomes necessary, in our discretion, to turn an overdue account over to our attorney for collection, you will be responsible for costs of collection, to include court costs and attorney's fees actually incurred in the collection of your account.

   Please note that, unless canceled at least 48 hours in advance, you may be charged for missed appointments at the rate of $60.00. Please call the office as soon as possible if you have to reschedule.

PLEASE INITIAL_____

We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account.

Again, thank you for choosing our practice as your dental care provider. We appreciate your confidence and the opportunity to serve you.

BY SIGNING THIS FORM YOU HAVE READ THE ABOVE AND FULLY UNDERSTAND THE TERMS.

Signature _____ Date_____