Our Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful and to providing the highest quality dental services at a reasonable fee. Please understand that payment of your bill is necessary in order for us to provide treatment.

Patients with Dental Insurance

As a courtesy to our patients, we prepare and process all insurance forms. However, having insurance does not release the patient from financial responsibility.

Our expectations of you as the owner of the policy are as follows:

1. Estimated patient portions must be paid at the time of service. This may include co-payments, deductibles, co-insurance and/or non-covered procedures.
2. You are responsible for educating yourself about the details of your policy which includes deductibles, yearly maximums, and policy exclusions.
3. If the insurance company does not pay our office **within 60 days**, it is your responsibility to pay using one of the payment methods listed below. The insurance policy belongs to you and we have no leverage to obtain payment.

Patients without Dental Insurance

If there is no insurance coverage, full payment is due at the time of service with one of the payments listed below.

Payment Options

For your convenience, you may choose any of the following methods of payment:

- Cash
- Personal Check (postdated if necessary)
- Visa, MasterCard, Discover, American Express – Credit or Debit

Minor Patients

The parent, guardian or adult accompanying and signing all forms for a minor will be responsible for full payment. Parents or guardians must be present to authorize all dental treatment to minors.

Financial Agreement

I understand that I am financially responsible for all charges incurred by my dependents, or myself whether or not covered by insurance. I hereby authorize the office of Dr. Brady E. Benson to use the following signature for proof of signature on insurance claim forms for assignment of insurance payment and release of information. I agree to pay Dr. Brady E. Benson for professional services rendered to me at the time of service. If my insurance pays less than estimated, I agree to pay any remaining balance within 30 (thirty) days of billing. A $10.00 late fee will be charged to my account for each month a payment is not received. I expressly agree to pay all costs of collection agency fees assessed at 30% of the total amount due, and all court costs and attorney fees, if these terms are not met.

I grant my permission to you and your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to allow this office to leave messages concerning appointments and/or results on my answering machine or with a family member.

Failed Appointments

After 2 missed appointments, you will be charged a $50 fee and/or be dismissed from our office.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

____________________________________	______________________________	__________
Signature of Patient or Responsible Party	Print Name	Date

*See other side for more information