Office and Financial Policy

1. Our office will be happy to file claims for you at no charge. However, **we must ask you to be responsible for tracking claims for timely payment.** We will also expect you to **know your maximums, exclusions and policy limitations,** prior to treatment. We cannot accept the responsibility of knowing everything about your personal policy. Any **amount not paid by your insurance is your responsibility** regardless of any "estimation" of benefits made by our office.
2. **After 60 days all balances regardless of insurance becomes the responsibity of the patient**. Full payment is due upon receipt of 1st statement after release of balance to patient.
3. **All ESTIMATED coinsurance** (amounts not covered by insurance) **and deductibles are due in full at the time of service.** Please do not ask to be billed for these amounts. **Any account balance over 60 days** that requires multiple statements **will be charged a minimum $5 service fee per month** to help offset the extreme high cost of continuous billing. This will help keep our fees as low as possible for our patients.
4. A **48-hour notice is appreciated** for all cancellations. A **24-hour notice is required** if cancellation is necessary **to avoid a charge**. You may call and leave a message at our office 24 hours a day. A call left on the answering machine will be considered a 24-hour notice.
5. **Collection Accounts** – Accounts are sent to collections at 90 days past due unless payment arrangements have been made through our billing department. If you have allowed your account to be sent to collection, we are only willing to see you on an emergency basis for thirty days. After the thirty days, we will be happy to transfer your dental records to an office of your choice.

Financing is available for your dental work through an outside finance company or you may pay by* Visa, MasterCard, American Express, Discover, check or cash. *Please speak to the Office Manager or front desk BEFORE work is done if financing is needed for any visit.

I have read and understand the above financial policy and agree to the terms as stipulated by Van Buren Dental. I further consent to treatment and filing of all insurance claims (if applicable) on the behalf of myself and/or dependents and assignment of benefits to Van Buren Dental.

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(Guarantor/Patient) (Date)