North University Dental

FINANCIAL POLICY

The goal of North University Dental is to make sure you receive the highest dental care and services. One step is to make certain our financial policy is clear and understood by you.

1. **PAYMENT** is expected at the time of your visit. We accept cash, check, credit card, Care Credit or Cherry. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company.

   If you do not carry insurance, or if your coverage is under a pre-existing condition clause, payment in full is expected at the time of your visit.

   A 5% professional courtesy is given to patients that do not have insurance when paying in full at the time of services. Payment by cash or check is necessary to receive the discount.

   **** We require a credit card to be kept securely on file. Any balances remaining unpaid after 60 days will be charged to the card on file.***

2. **INSURANCE:** We will bill your insurance carrier as a courtesy to you. Please note that not all services are covered benefits in all insurance contracts. We recommend that you become familiar with your insurance coverage and limitations. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Payment is due upon receipt of a statement from our office.

3. **CANCELLATIONS OR MISSED APPOINTMENTS:** We respectfully request a ***48 hour notice*** for any scheduling changes***. If we do not receive the requested notice, or if you no-show, we will assess you a $50 missed appointment fee*****.** Credit cards will be kept on file in a secure location.

4. **COLLECTION FEES:** I understand that ***if my balance is not paid in full within 90 days*** **then** ***my account will be sent to collections*****.** I also understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, and interest. I understand that these additional fees will be my personal responsibility to pay in full.

5. **DIVORCED/SEPERATED PARENTS OF PATIENTS:** By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

6. **ASSIGNMENT AND RELEASE:** I authorize payment to be made directly to *North University Dental* by my insurance company and I accept financial responsibility for all series not covered by my insurance. I authorize release of any dental care information requested by my insurance carrier.

7. **PATIENT RESPONSIBILITY:** I acknowledge my responsibility for payment of the services received from *North University Dental* in accordance with their regular fees and terms. I understand my responsibility is not modified by whether my insurance pays for all, part, or none of the charges. Additionally, I understand my account may be turned over to a third party for collection should I fail to pay for services provided.

I have read and understand the practices financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of patient (or Guarantor, if applicable) **Date**

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Please print the name of the patient