Twin Cities SEDATION

Financial Guidelines

Patients Without Dental Insurance

1. Cost of treatment is due the day service is rendered.

Patients With Dental Insurance

1. Patients are responsible for providing our office with correct and updated insurance information.
2. Patients are responsible for knowing their insurance benefits.
3. Patients are responsible for any portion of treatment cost their insurance company does not cover.
4. Estimated patient portion is collected the day service is rendered. As a courtesy, we provide a treatment plan for all recommended treatment. This treatment plan includes the **estimated** out-of-pocket expense for the patient. Please keep in mind when insurance is used as a form of payment, we can only estimate the balance due. Our office has no way of knowing if and exactly how much insurance will pay.
5. A treatment plan is not the same as a pre-authorization from the insurance company. Pre-authorizations are done upon patient request and should not be considered a guarantee of payment from the insurance company. Even with pre-authorization, the insurance company may choose to pay a different amount. Final payment decisions are made by the insurance company after the services are rendered. **Patients should be aware they may be required to pay more despite having a pre-authorization.**
6. When utilizing two or more insurance companies there may be a delay in determining the balance due after insurance has paid as each insurance company has 30 days to respond to any claim submitted. A claim can only be submitted to one insurance company at a time.

All Patients

1. The only financing we offer is through Care Credit. Care Credit is a healthcare credit card.
2. Invoices are typically mailed after all outstanding insurance claims have been processed.
3. A finance charge of 0.5% may be assessed on all account balances not paid within 30 days of the invoice due date.
4. Accounts that have had three consecutive invoices and no payment may be referred to a collection agency.
5. Any refund due will be provided in original form of payment, with the exception of cash which will be refunded via check.
6. We reserve the right to dismiss you, and any patient associated with your account, from our practice due to non-payment. Dismissal means we will no longer see you as patients.

Please sign below to acknowledge that you have received this copy of our Financial Guidelines:

Patient Signature: _____ **Date: _____**

Print Name: _____