Hayes Family Dentistry p.c.
Gentle, affordable dental care for the whole family

FINANCIAL POLICY

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE

In the effort to hold costs down, payment is due when services are rendered. For services exceeding $300.00, you may apply for a payment plan through our preferred financial agencies which must be arranged and approved in advance of your appointment. I understand, where appropriate, credit bureau reports may be obtained to facilitate this.

As a courtesy to our patients who have Dental Insurance coverage, we will be happy to file your claim electronically. Your estimated portion (deductible and co-pay) is due in full at the time of service. We will figure these amounts for you using the information provided by your plan. Any amount exceeding your annual maximum is due when your service is rendered. In the event your insurance claim is not processed in a timely manner, we will file the claim a second time. However, further delays caused by the insurance company resulting in payment passed 45 days, will require you to make full payment to our office. Any payment received from you insurance company after that will be reimbursed to you once your total account balance has been resolved. To expedite processing, you will need to contact the insurance company directly.

Any insurance benefits you have are an independent contract between you and your carrier. You are ultimately responsible for any balance not paid by the insurance company. In addition, you are responsible for keeping us informed of your insurance status so that we may obtain your insurance benefits in a timely manner.

If you are unable to make any scheduled appointment, it is important that you call our office as soon as possible so that we can make other arrangements. We require notification two business days in advance so that we may accommodate another patient. A $50.00 fee will be assessed to those not able to comply with our guidelines.

Delinquent accounts are processed for collections following the guidelines of the Fair Debt Collection Practices Act. If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls, including autodialed calls and prerecorded messages at that wireless number from Hayes Family Dentistry, PC, it successors and assigns, and the affiliates, agents and independent contractors, including servers and collection agents, of each of them regarding the services rendered, or my related financial obligations. I understand that all reasonable collection costs/attorney fees on any past due amounts will be my responsibility. Returned checks will be assessed a $30 NSF fee.

I have read, understand, and agree to the above FINANCIAL AGREEMENT.

_____ _____

Signature Date

I assign my insurance benefits to be payable to Hayes Family Dentistry, PC.

_____ _____

Signature Date