# *Financial Policy For Dr.Kopp & Dr. Bloom, D.D.S. PC*

**Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.**

## *PAYMENT*

Payment in full is due at the time of service unless prior financial arrangements are made with the doctor and billing coordinator. We offer several payment options:

· Cash · Checks · Visa, MasterCard · Care Credit

· Short-term monthly payment plans in accordance with the office credit guidelines

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

**MINORS:** Payment for services for the treatment of minors is the responsibility of the adult accompanying that minor. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment to an approved payment plan , or payment by cash, check or credit card at time of service have been received.

**SERVICE CHARGES:** If a payment schedule has not been arranged, it is the policy of this office to charge 1% interest monthly (12% annual percentage rate) or a billing charge to all accounts over 90 days past due. There will also be a $40 fee for returned checks to cover processing fees that are charged to our office.

**COLLECTION FEES:** Fees incurred to collect payment will be billed to and are payable by the patient's account holder.

## *INSURANCE*

Your insurance policy is a contract between you and your insurance company. Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith but cannot guarantee it. As a courtesy to our patients, we will be happy to submit all claims on your behalf.

Please be aware that some and perhaps all of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided.

Insurance claims cannot be backdated. All insurance co-pays and deductibles must be paid at the time of service.

## *MISSED APPOINTMENTS*

It is the patient's responsibility to keep scheduled appointments. Our office makes every attempt to remind patients of their appointment through confirmation calls and postcards. This reminder is a *courtesy* offered by our office.

Please keep all appointments. Once an appointment has been made, that time is reserved specifically for you. Rescheduling increases treatment time and can turn into increased costs. If rescheduling is necessary, we would appreciate at least 48 hours advance notice. If you are unable to give our office at least 24 hours notice, we reserve the right to charge a $50 missed appointment fee.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient Name: _____Date_____

(Please Print)

Signature of the Patient or Responsible Party _____ Revised 04/14