OUR FINANCIAL POLICY

The following financial policy has been established in an attempt to accommodate our patients and at the same time meet the cash flow demands of our dental practice.

Unless prior arrangements have been made with the business office, we ask for full payment at the time services are rendered. We accept cash, check, MasterCard, Visa, and Discover. As a service to you, we will file claims and accept assignment of benefits from your primary insurance carrier. Any deductibles, co-payments, second carrier amounts and services not covered by insurance are to be paid at the time of treatment. Our bank charges us for any returned checks; therefore, there will be a returned check fee of $15 for all returned checks. We also have a broken appointment fee. There may be a charge for any appointments cancelled with less than 24 hour notice, coming too late to be seen, or missing a scheduled appointment. We do not file claims to Medicare.

If you have dental insurance and haven't already done so, please provide us with a copy of your insurance card and dental handbook given to you by your employer. We will make a copy of them, and contact your insurance company to verify coverage and benefit information. It is our desire that you receive the maximum benefit possible from your dental insurance. We gladly will help you in doing this.

We have found that most insurance companies provide payment at a level that they set themselves. We take great care in setting our fees well within the acceptable norms for similar services available in this area. If you find that your insurance plan does not cover certain services or that it pays below our usual charge, we encourage you to discuss this with your insurance carrier and your human resources department. We ask you to assume responsibility for informing us of your benefit guidelines and limitations and that you remember the ultimate responsibility for full payment for our services rests with you.

I HAVE READ AND I UNDERSTAND THIS EXPLANATION OF THE FINANCIAL POLICY OF BARTLETT DENTAL ASSOCIATES.

Adult Patient/Guarantor: ____
Date: ____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Bartlett Dental Associates to furnish information to my insurance carrier concerning my dental treatment and I hereby assign to Bartlett Dental Associates payments for dental services rendered to myself or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS NOT COVERED OR PAID BY MY INSURANCE COMPANY.

Adult Patient/Guarantor: ____
Date: ____