Financial Policy – Office of Vincent J. Daniels, DDS

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to our professional relationship. Prior to treatment, you must complete our patient information and medical history forms, read and approve our privacy policy and submit your insurance card for photocopying. Please ask if you have any questions about our fees, financial policy or your responsibilities.

Your appointment time is reserved exclusively for you. If you cannot keep your appointment, you must provide our office with a 48-hour notice to avoid a broken appointment fee of $50.00.

We will do everything we can to inform you in advance of the anticipated costs of your treatment, including an estimate of the benefit your insurance company is likely to pay. Such information does not preclude the possibility that additional costs may be incurred if unanticipated treatment becomes necessary, nor will it absolve you of your obligation to pay for such treatment. Keep in mind that your treatment needs are not connected to or determined by your insurance benefits.

Insurance is a contract between you and your insurance company. Not all services are a covered benefit in all contracts. We file insurance claims as a courtesy to our patients. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered services, "usual and customary" allowances or other issues other than to provide factual information as necessary. **You, the patient, are ultimately and completely responsible for payment of your account.**

Insured patients are required to pay the **estimated** cost of their care (co-payment) at the time of service. If you do not have insurance, or if your insurance will not reimburse us directly (for example: Delta Dental or Out-of-State Blue Cross Blue Shield), payment in full is expected at the time of service, unless otherwise arranged in advance.

There are payment options available for those who are unable to pay in full at the time of service. These options must be agreed upon prior to treatment being rendered. Please ask a member of our staff to further elaborate.

During the normal course of business we, or our agent, may pull your Credit Report. The purpose of this is to verify identity in an attempt to reduce fraud. This office does not extend credit, so your Credit Score is irrelevant to us.

Interest at the rate of one and one-half percent per month will be added to your account until the balance has been paid in full. A non-sufficient funds (NSF) fee of $50.00 will be added for each dishonored check. It is your responsibility to pay for any costs of collection including, but not limited to court costs, collection agency fees and/or attorney's fees, incurred by this office, our agent or our assignee.

If an account is referred to, or purchased by, a collection agency, a fee will be assessed (33.3% of the outstanding balance) and added to your ledger. In addition, you will be responsible for any fees added by or incurred by the collection agency collecting this debt, including, but not limited to: interest fees at two-percent per month, court costs, US postage, certified mail costs, credit report/skip-tracing costs, courier service and process server fees.

If there is ever a dispute with respect to the amount owed on your account, you must notify this office, in writing, within 30-days of invoice date. For our mutual records, we suggest you send this correspondence via certified mail.

I have read the above policy and understand my responsibility for my account. **I, the patient, am ultimately and completely responsible for payment of my account and agree to the above terms.**

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Complete Printed Name – First / Middle / Last / Jr, Sr, III, IV Social Security Number

Assignment of Benefits

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to Vincent J. Daniels, DDS of the benefits otherwise payable to me.

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Signature of Patient or Responsible Party Date