ROCK ISLAND

ESTD DENTAL ASSOCIATES 2021

Financial Policy

Our goal is to provide the highest quality of dental care possible and to have clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT TIME OF SERVICE. If a procedure requires multiple appointments, payment is required in full at the first appointment unless prior arrangements have been made with our financial coordinator.

Payment Options:

1. Cash
2. Credit card (all major cards are accepted)
3. Check
4. Care credit
    a. Plan may not exceed 12 months

Patients with insurance: *We are not in network with any/all dental insurance companies*. The **PATIENT** is responsible for the **ESTIMATED** non-covered portion, procedures, and/or deductibles at the time of service.

It is the patient's responsibility to make us aware of any dental benefits used at another dental/specialist office. This may affect the estimated patient portion due.

We file your insurance claims as a courtesy. The TOTAL charges are the patient's responsibility regardless of your insurance coverage. Insurance benefits are dictated by the plan your employer (self) participates with. It is the policy holders' responsibility to understand his/her benefits.

Parents accompanying their children are financially responsible for payment. **Parents NOT accompanying** their children to an appointment must make PRIOR arrangements for payment.

Return checks will be accompanied by a **$100 fee** to the patient's account. Use of personal checks for payments following a returned check will be prohibited.

Insured patients

- I understand my insurance may only provide coverage for the minimum standard of care. **INITIAL: _____**
- I understand that submitting insurance and receiving a benefit is my responsibility and that any assistance from Rock Island Dental Associates is completely voluntary. **INITIAL: _____**
- Regardless of the response from my insurance carrier, I elect to follow the dentist's recommendation for optimal dental treatment. **INITIAL: _____**

We have the right to charge interest to unpaid accounts. If any action is brought to enforce the terms of this Agreement, our office will be entitled to recover its reasonable attorneys' fees, costs and expenses from the patient, in addition to any other relief to which the prevailing party may be entitled.

I have read the above terms and conditions of Rock Island Dental Associates and agree to their terms.

Patients Name: _____ Signature: _____ Date: _____