AUSTELL DENTAL ASSOCIATES:
FINANCIAL & PATIENT RESPONSIBILITY POLICY

The purpose of this form is to inform all patients of our financial policies and your responsibility in regard to charges incurred in our practice. We realize how confusing insurance reimbursement has become and hope this policy will answer any questions you have regarding charges from our practice.

If we will be filing insurance, you will be responsible for making your co-payment and/or any deductible owed at the time of service. We will provide you with the best possible estimate of your obligation and ask that you pay this at the time of service**. You will also be responsible for any non-covered services at the time of service.**

If we do not have your current insurance information, then payment is expected at the time of service. We will file all dental insurance claims for our patients **as a courtesy**. This does not transfer your financial obligation to your insurance company. We will bill you for any balance left after your insurance company pays us and all applicable write offs have been taken. **It is your responsibility to let us know of any insurance changes.**

Accounts with past due balances are subject to a monthly service charge. If you are unable to pay your account in full, we will be happy to create a mutually agreeable payment arrangement with you. As long as the terms of these arrangements are kept, your account will remain in our office for collection. If the payment arrangement is not kept, we reserve the right to forward the account to an outside agency for collection.

This dental office only uses resin (tooth colored) fillings. It is possible that your insurance company will not allow for these fillings. You are responsible for the cost difference between the resin fillings and the amalgam (silver) fillings.

Please understand that it is your responsibility to know and understand your insurance coverage and that you are financially responsible for all charges incurred in our office.

Please call 24 hours in advance if you need to reschedule your appointment. We understand that occasionally circumstances prevent advance notice but if multiple appointments are broken you may incur a **$50.00 Broken Appointment Charge.**

I have read and understand the above policy. I give permission for any information regarding my dental care to be released to my insurance company for payment consideration.

Print Name_____

Patient
Signature_____Date_____