

INSURANCE: It is extremely difficult for our office to keep track of all the individual requirements of all dental insurance plans. Even within the same insurance company plans differ depending upon what type of contract your employer has negotiated. It is always to your benefit to contact your insurance company directly if you have any questions concerning your coverage.

Please keep in mind that your insurance coverage is a contract between you and the insurance company. We are a third party and we have no financial responsibility if for any reason your insurance company does not honor their commitment to you or to us. **You are completely responsible for your account.**

PAYMENT: You are expected to pay your deductible and estimated co-payment at the time of your appointment. We will file your claim with your insurance company and accept assignment of your benefits. If your insurance company denies payment or pays less than estimated we will expect you to pay the balance in full. **Any account not paid in full after 30 days will incur a billing charge of \$5.00 monthly, until paid in full.** Please note: A \$25.00 fee will be charged for all returned checks.

If it becomes necessary to turn your past due balance over for collection you will be responsible for all reasonable associated fees.

X-RAY TRANSFER: The Indiana Patient Records Act requires Indiana dentists to maintain the original health records of their patients for at least seven years. A fee for the duplication of these records and/or x-rays will be charged.

FAILED OR RESCHEDULED APPOINTMENTS: In order to be of service to other patients, we ask that you inform us of cancellations or the need to reschedule 24 hours in advance. The fee for appointments that are missed or rescheduled without 24 hours notice is \$50.00.

Signature _____ Date _____

Initial for copy received _____

2015