FINANCIAL POLICY- OFFICE OF MAIN STREET DENTAL

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 anticipation 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 included 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 you 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.

Payment for dental treatment is always due at time of service. If you do not have insurance, or if your insurance will not reimburse us directly (for example: 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 unable to pay in full at time of service. These options must be agreed upon prior to treatment being rendered. Please ask a member of our staff to further elaborate.

After 90- days of invoice date, all accounts are subject to interest. Interest at the rate of one percent per month will be added to your account until the balance has been paid in full.
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 the debt.

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.

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Signature of Patient or Responsible Party **Date**

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Complete Printed Name- First/Middle/Last/ Jr., Sr., lll, IV

ASSIGNMENT OF BENEFITS

This signature on file is my authorization for the release of information to process my claim. I herby authorize payment to Main Street Dental of the benefits otherwise payable to me.

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Signature of Patient or Responsible Party **Date**