Financial Policy of Broad Ripple Family Dental

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimal oral health. Please understand that payment is considered part of your treatment.

All scheduled appointments do REQUIRE a verbal, text message, or email confirmation no later than 48 business day hours. Failure to do so will result in loss of appointment slot.

If you cancel an appointment with less than a 48-hour notice, or you fail an appointment, there will be a $50.00 fee added to your account.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and Care Credit. Please Note: returned checks will be subject to additional fees.

If you have insurance:

- As a courtesy to you, we will help you process all your dental insurance claims. Please understand that we will provide an insurance estimate to you: however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer and your insurance company. Our office is not party to that contract.
- Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination if usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company directly to our office.
- We ask that you pay the deductible and co-payment, which is an estimated amount, not covered by your insurance company, by cash, check, MasterCard, Visa, Discover or Care Credit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected soon. If payment by your insurance company is not received within 60 days or your claim is denied, you will be responsible for paying the full amount at that time.
- Minors with divorced parents
  When two parents are each responsible for one half of the cost of a child's dental care, the Parent or Guardian who brings the child is responsible for the co-insurance or the full fee. They will be responsible for collecting payment from the other parent.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

For your convenience, we also offer automatic payments to your credit card as a form of payment. Please let us know if you would like to use this method of payment, as there is an additional authorization form to sign. (Exclusions Apply)

In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any collection and/or legal charges incurred, along with any charges associated with those agencies, and/or finance charges.

I/We agree that in the event of default in payment, responsible collection fees, forty (40) percent of the delinquent balance and reasonable attorney fees shall be added to the amount due on the account, plus any applicable court fees.

_____ _____

Initials Date

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office.

_____ _____ _____

Patient Name Patient Signature (or guarantor if minor) Date