Endodontics, PA
Financial Policy

Thank you for choosing our office as your endodontic healthcare provider. We are committed to providing you with the highest quality endodontic dental care so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read, agree to, and sign prior to any treatment. Please read the following information and initial and sign in the appropriate sections.

Initials

_____ **Payment**

- Payment (insurance co-pay or full fee) is due at the time services are provided. We do not bill.
- We accept cash, personal checks, and the following credit cards: Visa, Mastercard, and Discover.
- A $35 service fee will be applied to all returned checks.
- A 1.5% monthly finance charge will be applied to all outstanding balances after 60 days.

_____ **Insurance**

- As a courtesy to our insured patients we will verify your dental insurance coverage prior to your appointment and determine a co-pay **estimate** that is due at the time of service. Please be aware: This is only an **estimated co-pay**, and is subject to the limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums as determined by your insurance company at the time the claim is processed. We cannot guarantee payment by your carrier, and it is ultimately your responsibility to be familiar with the benefits and exclusions of your insurance plan.
- Our office will submit all claims to your insurance carrier in a timely manner. Insurance claims are typically processed within 30-60 days; however, there are times when claim processing may take longer. We will work to resolve any issues with your insurance company to the best of our ability. Issues that cannot be resolved after 90 days will become the responsibility of the patient. We must stress – our relationship is with you, our patient, and not your insurance company.
- All charges incurred are your responsibility, regardless of your insurance coverage.

_____ **Minors accompanied by a parent/legal guardian**

- All patients under the age of 18 must be accompanied by a parent/legal guardian. The parent/legal guardian accompanying a minor, who consented to treatment and signed all paperwork, is responsible for payment and is required to stay for the duration of the appointment.

_____ **Missed appointment and cancellations**

- It is extremely important for your dental health that you keep all scheduled appointments.
- We require at least 24-hour notice for cancellations/rescheduling. To assist you, we provide a 24-hour answering service.
- A $50 service charge will be applied for any appointment for no-shows or same-day cancellations.

_____ **Communication**

- By signing below, you are authorizing us to contact you and leave a message regarding insurance issues and account balances on any phone number/email address provided by you.

Financial Policy Agreement: My initials above and my signature below indicate that I read, understand, and agree that I am ultimately responsible for the balance on my account regardless of insurance status for any services rendered. Failure to pay for endodontic services within 60 days will incur a 1.5% finance charge, as well as any attorney fees, court costs, and certified mail charges incurred while recouping the balance.

Signature: _____ **Date:** _____