Austin & Reid, DDS, PLLC
Financial Policy

Thank you for choosing us as your dental care provider. Our doctors and staff are committed to providing you with the best possible care. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment being rendered.

Regarding Payment

1. We accept the following forms of payment: Cash, Check, Visa, MasterCard and Discover.

2. Payment is due at the time services are rendered in full, unless prior arrangements have been made with our financial coordinator prior to your treatment appointment.

3. Appointments for crowns, bridges, dentures, partial dentures and other prosthetics are to be paid in full before the product is delivered to you unless prior arrangements are made.

4. Checks returned to our office from your financial institution are subject to a $25.00 returned check fee. This covers processing fees that are charged to our office.

5. Responsibility for payment of services rendered to child(ren) of divorced or separated parents rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved without including our office staff. We cannot send duplicate statements.

Regarding Insurance (Benefits)

Your dental benefits, provided by your insurance company, is a contract between you, your employer and your insurance company. Our office is not a party to that contract. Due to the many different possible benefits provided by each insurance company, our staff cannot guarantee your eligibility or coverage. We are pleased to seek payment from your insurance company as a service to you. We can also provide an ***estimate*** of what is covered based on the information your insurance company has provided to us. However, ***it is your responsibility to know your benefits provided by your insurance company and any exclusions.***

Complete and accurate insurance information MUST be presented before your appointment time. If you do not provide us with the correct insurance information in a timely manner, you will be responsible for the entire balance. Please be aware that the balance of your account is your responsibility whether or not your insurance company pays your claim. Claims cannot be backdated or held for future submission.

RESPONSIBLE PARTY AND INSURANCE INFORMATION

Name: _____Relationship to patient: _____
SS#: _____ID#: _____Birthdate: ____/_____/_____
Employer: _____ Insurance Company: _____Group #: _____

Secondary Insurance Coverage

Name: _____Relationship to patient: _____
SS#: _____ID#: _____Birthdate: _____/_____/_____
Employer: _____Insurance Company: _____Group #: _____

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Please note***, most benefit plans do not cover all services and are designed to only cover a portion of the total cost***. In the event your benefit plan determines a service to be "not covered", you will be responsible for the fee. We must emphasize though, as your dental care provider, our relationship is with ***you***, our patient, and that we diagnose and treat based on your dental needs and not by what your dental benefits may or may not pay for.

Regarding Broken or Missed Appointments

All scheduled appointments are reserved just for you. If unable to keep your appointment, we would like you to notify us at least 48 hours in advance. We understand when emergencies happen or unforeseen circumstances prevent you from coming to your appointment. However, in case of any missed appointments, we reserve the right to apply a broken appointment fee to your account. Our broken or missed appointment fee is anywhere from $50 to $150 depending on how much time was set aside for you. A dental office is different than a medical office in that we are unable to schedule more than one patient at a time so when one patient is not able to show up there is lost time and we have a waiting list that we may have been able to have put someone in that appointment time.

These fees are not covered by insurance carriers and will be your responsibility to pay at the time of your next visit. Our aim here is to open otherwise unused appointments and keep a timely schedule for our patients, not to collect missed appointment fees. Please note, more than 3 appointments missed within a 12-month period may be cause for dismissal from the practice. Your cooperation and consideration are appreciated as we institute this policy.

Thank you for reading and understanding our Financial Policy. Please address our front desk staff if you have any questions or concerns.

****

I have read the Financial Policy and fully understand and agree to its' terms and conditions.

Patient Signature (Responsible Party):

_____Date_____