SPECTRUM
FAMILY DENTISTRY
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# FINANCIAL POLICY

Welcome to our office! We are honored that you have chosen us as your dental care provider and look forward to working with you. Our dental practice team is committed to providing an excellent dental care experience to you and your family and has implemented the financial policies outlined below to assist in that regard. These financial policies are followed by our practice so that we can stay focused on what we do best – providing you with personalized, comprehensive dental care services. Thank you in advance for your cooperation. We trust that you understand and appreciate the need for a clear policy regarding your account. Please read the financial information and sign at the end. Please feel free to ask any questions of our staff.

1. We kindly accept cash, debit or credit cards, and care credit plans. No checks please.
2. We recommend the best dental care for you, regardless of dental insurance limitations.
3. Your insurance is a contract between you, your employer and the insurance company
4. Deductibles (for those with insurance) or full payment (for those without insurance) is due at time of service unless prior arrangements have been made with the office manager.
5. You are responsible for all charges regardless of **ESTIMATED** insurance coverage. This is usually a rough estimate because the insurance company does not want to reveal maximum reimbursement fee (the so called "UCR" or Usual, Customary and Reasonable fee). Please remember that no insurance company attempts to cover all dental costs.
6. For children of divorced parents, the parent bringing the child for treatment will be held responsible for payment at the time of service unless other arrangements have been made in advance. We will provide you with any information for the other parent when necessary and appropriate.
7. A finance charge of 1.5% (18% APR) is added to all balances greater then 90 days. If we must pursue payment through our attorney for collections, you will be responsible for all added fees.
8. There is a $35.00 charge for all returned checks.
9. There is a $50 charge for last minute cancellations (less than 48 hours notice) or missed appointments/no show.
10. Claims not paid after thirty (30) days will be billed to you for payment.
11. In the event that you receive an insurance payment after dental services are rendered, you must forward the check payment to our office to be applied to your outstanding balance.

**RESIN-BASED COMPOSITE RESTORATIONS (Tooth-Colored Fillings): Most dental insurance plans do not allow full benefits for composites (tooth-colored fillings) performed on posterior teeth (bicuspids and back molars). The plan benefit will customarily pay for a less expensive treatment - amalgam (silver/mercury-based restoration). In order to provide the best treatment for our patients, we recommend and we place *only* resin-based ("tooth- colored") fillings. The cost difference per filling ranges from $10 - $50 and the patient is responsible for the difference in cost. Please ask our front desk or doctors if you need more information about resin-based "tooth- colored" fillings.** **Initials:_____**

It is further understood that, since your insurance is a contract between you and your insurance company/employer, the practice cannot assume responsibility for coverage or other determinations made by your insurance company and that you will be responsible for timely payment for all treatment received from the practice regardless of your insurance status. Furthermore, I authorize any representative of Spectrum Family Dentistry to receive any payment due for any dental treatment planned or rendered. Please indicate your understanding and acceptance of these financial policies by signing below. For the mutual convenience of you and the practice, it is understood that this executed copy of the Financial Policy also shall cover your dependent children who are patients of the practice.

I agree to the above financial policies set forth by Spectrum Family Dentistry.

**Signature of Responsible Party: _____** **Date: _____**