Inland Dental Group

Financial Policies

PATIENT NAME_____

INSURANCE

As a courtesy to our patients we gladly process your insurance claims for services rendered in our practice. We participate in many insurance plans, but please inquire if we accept your insurance to avoid billing problems later. We *ESTIMATE* your deductible for the year and your patient portion due that is not payable by your insurance. The total portion that is not payable by insurance is *DUE AT THE TIME OF SERVICES RENDERED*. Parents *MUST* send co-pays due with minors or adult bringing patient at the time of their appointment. Initial _____

MISSED APPOINTMENTS/ CANCELLATIONS

Forty Eight (48) hour notice is required for rescheduling or cancellation of appointments. We reserve the right to charge a fee for broken appointments or ones that are not cancelled beforehand within a reasonable time frame. If repeated *"NO-SHOWS"* occur, you will be discharged from our care. Initial _____

PAYMENT OPTIONS

1. Cash
2. Personal Check
3. Visa, MasterCard, Discover and American Express
4. Care Credit, Lending Club, Wells Fargo Health Advantage (These programs offer patients a line of credit to cover you or your family's dental care needs. In most situations these are interest free programs that allow you to begin your treatment immediately and spread the cost over a period of time. Inquire with office staff to attain further information regarding the different programs offered. Initial _____

ADMINISTRATIVE FEES (If Applicable)

- Returned checks are subject to a $25.00 fee
- If collection and/or legal services are required to obtain payment, I further agree to pay for all legal fees and cost incurred. Initial _____

I understand and agree that regardless of my insurance (if applicable), I am ultimately responsible for the balance on my account for all charges and services rendered. I have read all information on this sheet and understand the above policies.

Patient Signature: _____ Date: _____

Parent/ Guardian Signature (For Minors): _____ Date: _____