

LIFETIME DENTAL CARE

FINANCIAL POLICY

Thank you for selecting us as your dental health care provider. The following information describes our Financial Policy and we ask that you read and sign our policy prior to seeing the dentist. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health.

Payments for service is due at the time services are rendered. We accept cash, personal checks, and for your convenience MasterCard, Visa and Discover. We have financing options available.

PATIENT BENEFITS/RECORDS RELEASE

I authorize Lifetime Dental Care, to release medical/dental information, as it is necessary to bill my insurance carrier. In addition, I authorize my insurance carrier to release payments of insurance benefits directly to Lifetime Dental Care.

COPAYS/DEDUCTIBLES

All unpaid deductibles and co-payments are due at the time of treatment.

GUARANTOR LIABILITY/RESPONSIBILITY

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. If your insurance company pays off of an amalgam (silver) filling fee schedule you will be responsible for the difference between the amalgam (silver filling) fee and the composite (tooth colored) filling fee. Our office applies a finance charge of 5% on any account past 60 days and a late fee of \$25.00 on any account not paid in 90 days.

Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our financial relationship is with you, not your insurance company.

Please note that, unless cancelled at least 24 hours in advance, you will be charged for missed appointments at the rate of \$40.00 per ½ hour of your appointment time.

I have read and understand the above policies. My signature constitutes my acceptance of these policies.

Patient Signature: _____

Date: _____