

Kelley L. Borders DMD

Dental Financial Policy

Thank you for choosing our office as your dental health care provider. Our primary responsibility is providing the highest quality dental care for you and your dependents. Part of our commitment is your understanding and responsibility for the payment of your balance.

- All patients must complete our Patient Information Forms before seeing the dental professional.
- Full payment is due at the time of service.
- We accept cash, checks, American Express, Visa, MasterCard, Discover and Care Credit.
- We will bill your PPO insurance company as a courtesy. The patient portion of dental services is estimated and due at the time of service.

Adult Patients

Adult patients are responsible for full payment of time of service.

Minor Patients

The adult accompanying a minor or his/her parents or guardians, are responsible for FULL payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by credit card, cash or a check at the time of service.

Insurance

Our practice provides insurance billing as a courtesy to our patients. The patient portion of dental services is estimated and **DUE AT THE TIME OF SERVICE**. If you or your family exceed the annual limitations in any plan year, YOU will be responsible for the **FULL** amount of dental services. You, as a patient are always responsible for any charges that are not covered by your insurance. If you have two dental carriers, we will file the primary claim, but it will be **YOUR** responsibility to file and follow up any secondary claim. We will gladly do a pre-treatment estimate if **REQUESTED** to determine the schedule of benefits for the services to be rendered.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for the quality of the treatment that is rendered. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will do all that is reasonable and proper to have you receive the maximum insurance benefits you are entitled too.

Patient Responsibility and Additional Terms

Accounts unpaid for 90 days from day of service are subject to a delinquent fee of \$35.00. The unpaid balance is subject to a 1.5% monthly (18% Annual) finance charge. If we must submit your unpaid balance to a collection process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney's fees.

Missed Appointments/Returned Checks

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$25.00 per appointment. Please help us service you better by keeping the scheduled appointments. Any returned check will carry a \$40.00 fee.

I have read this *Financial Policy*. I understand and agree to the terms of the *Financial Policy of Kelley L Borders, DMD*.

X _____

Date: _____

Signature of Patient or Parent of Minor