Natasha Rados, D.D.S

FINANCIAL POLICY

_____

(Please Print Name)

We are committed to providing you with the best possible dental care. We also want you to be aware of our financial policy.

Payment is due at the time of treatment unless payment arrangements have been made. We accept cash, checks, Visa, MasterCard, American Express, Discover and CareCredit.

Returned checks will result in a $30.00 charge to your account.

Your appointment time is reserved exclusively for you. We require 48 hours notice to avoid a broken or failed appointment fee of $75.00 per hour.

Account balances over 60 days will incur an 18% APR finance charge. Accounts greater than 90 days will be forwarded to an outside collection agency unless financial arrangements have been made.

Dental Insurance

For our patients who have dental benefits, our relationship is with you, not your insurance company. We do our best to facilitate your dental claims. However, we are not agents of your insurance company. Your insurance benefits are a contract between you and your insurance company. *We are not party to that contract.*

You are responsible to give us your correct insurance information. If you change your insurance, you are responsible to give us the new information. If you do not inform us of any change, and do not give us a copy of your current insurance card, you accept full financial responsibility for all charges.

If we are able to verify your insurance coverage, eligibility and benefits, we will bill your insurance company and accept assignment. Any deductible(s), co-pay(s) and/or coinsurance(s) are your responsibility and are due at the time of treatment unless payment arrangements have been made.

We will file your dental claim and will make every attempt to collect from your insurance provider. If all collection means have been exhausted on accounts greater than 60 days, you will be responsible for payment. Once your insurance has been paid, if you have a remaining balance, you will be responsible for payment.

I understand that I am responsible for my account and will assist in any means to collect from my insurance provider. I authorize my insurance company (ies) to pay directly to Natasha Rados, D.D.S. any dental benefits to which I am entitled. I also authorize the release of identifiable personal information and medical records to my insurance company (ies) or designated representative.

I have read and understand the above policy.

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(Signature) (Date)

Notice Effective Date: June 2007