Allred Family Dental
Financial Policy

PAYMENT IS EXPECTED AT THE TIME OF SERVICES

Payment is required at the time services are rendered unless other arrangements are made in advance. This includes applicable co-insurance, co-payments and deductibles for participating insurance companies. We accept cash, Visa, MasterCard, Discover, American Express, and Care Credit. **We do not accept checks.**

Payments with an outstanding balance 60 days or more overdue must make payment arrangements prior to scheduling appointments. We do use a collection agency to pursue past due accounts.

INSURANCE

We bill participating insurance companies as a courtesy to our patients. Every effort will be made to verify benefits and eligibility prior to any treatment completed. **An estimate will be given to you for any procedures done. This is an estimate only and not a guarantee of coverage. Changes to your treatment during the procedure may alter the cost of your care.** Because this is an estimate, after your claim is paid by your insurance company, you may receive a refund, or a bill from us. Ultimately it is **YOUR** responsibility to know your coverage. You are expected to pay your deductible, co-payments, and co-insurance. If payment is not received from your insurance company, you will be expected to pay the balance in full. It is your responsibility to notify us of any changes in your insurance coverage.

OUT OF NETWORK INSURANCE

If we are not in network (not contracted) with your insurance company, we will submit a claim as an out of network provider. **You are responsible for any portion not covered by your insurance company.**

MISSED, LATE, OR CANCELED APPOINTMENTS

Missed appointments represent a loss to our business, to you as a patient, and to other patients who could have been treated in the time reserved for you. Cancellations are requested 48 hours in advance of the scheduled appointment. If you fail to notify us within 48 hours of the scheduled appointment, a **$50.00** non-refundable fee will be charged. Excessive cancellations or missed appointments may result in discharged from the practice.

Please print and sign below to indicate that you have read and agree to the practice financial policy.

Print Patient Name Date

Patient or Guardian Signature Date