Oxford Dental Care

INSURANCE & FINANCIAL POLICY

THIS AGREEMENT IS TO INFORM YOU OF YOUR FINANCIAL OBLIGATION

We accept MasterCard, Visa, American Express & Care Credit, as well as cash or personal checks. We will be happy to discuss these options with you so that any dental treatment will fit into your budget.

Emergency Patients: We will file any insurance claims, as long as we can verify your benefits. If we are unable to verify these benefits, we will require payment in full.

Minors with separated or divorced parents. When two parents are each responsible for one half of the cost of their children's dental care, the **parent who brings the child to our office** is responsible for paying for the treatment.

There is a $35.00 fee for processing returned checks. Any checks that are not collectable will be turned over to the District Attorney's Bad Check unit of Anniston.

All charges you incurred are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with **you, not with your insurance company.**

I also understand that since **insurance plans are payment assistance plans,** they are not designed to cover the entire cost of treatment. **I understand that my dental insurance carrier may pay less than the treatment estimate given to me. The estimated co-payment may be adjusted after the time of service depending upon final payment from my insurance company.** If the insurance claim(s) are not paid in 60 days, the balance will become my responsibility.

Most insurance companies are now "deciding" which type of restorative filling the patient should receive, regardless of the clinical indication. While this office does everything possible to maximize the insurance benefits, I am aware that our doctors will diagnose the type of restorative filling that I need due to their standard of care, not what the insurance company decides. This will mean for some patients, based on the insurance company's benefit plan, composite resin (tooth colored) fillings on posterior teeth will only reimburse at the amalgam (metal) filling rate, with the remainder of the fee due from the patient.

I am also aware that if my balance becomes delinquent (30 days past due) the office reserves the right to charge a billing charge of $29.00 monthly. I am also responsible for any past due balance and all charges incurred if my account is turned over to a collection agency and/or attorney for services to collect any balance on my account.

I,_____, have read and understand the financial policies of this dental practice. I understand that I am ultimately responsible for **all fees** incurred for myself and my dependant children for our dental treatment.

By signing below I agree to the policy as stated in this document and I hereby authorized payment of the dental benefits otherwise payable to me directly to this dental practice and the release of any information relating to this claim to my insurance carrier.

_____ **Date**_____

SIGNATURE OF PATIENT/ OR GUARDIAN OF MINOR CHILD