Financial Policy

This describes our Practice's payment processing procedures for all 'services' (including films, examinations, treatment) rendered to you. In general, our Practice agrees to file accurate dental claims on your behalf to your dental insurance provider (primary only). Your dental insurance policy is a contract between your family and the dental insurance company. Patients are responsible for remaining balances resulting from appropriate claim processing. **Please read all applicable sections and sign to acknowledgement of our policies.**

PATIENTS WITH DENTAL INSURANCE: Valid dental insurance information must be provided to use to ensure appropriate reimbursement of your treatment. Patients are responsible for any pertinent deductibles, co-payments, non-covered services, resulting from dental claims processing; as well as any documentation or information required to process the claim. Failure to provide accurate or required information to ensure proper claims processing will result in immediate patient (or guarantor) responsibility.

CO-PAYMENTS: Co-payments are due before services are rendered. If you are unable to pay your co-payment today, your appointment may be rescheduled or a payment plan permitted with a promissory note, at the practice's discretion.

NO INSURANCE: Patient is expected at the time of service rendered, unless payment arrangements have been established.

STATEMENTS: On a monthly basis our Practice will mail you an account statement for any outstanding balances dues. Payment is expected within thirty (30) days. Failure to make timely payment will result in further collection actions.

PAYMENT METHODS: We accept payments by cash, check, and credit card including Care Credit. There will be a $10 returned check fee on all returned checks.

AUTHORIZATION/ASSIGNMENT OF BENEFITS: For services rendered to me, I hereby authorize the release of private information for the purposes of treatment and reimbursement for such care. In addition, I hereby authorize and assign benefits directly to Charter Oak Endodontics, Inc. I have read and understand the above described Practice payment policies and patient responsibilities pertinent to me (and/or guarantor).

Collection Agreement: I accept responsibility for charges not covered by my Insurance Carrier. I also agree to reimburse Charter Oak Endodontics for reasonable attorney's fees and collection costs in the event they become necessary to collect monies owed to Charter Oak Endodontics.

SIGNATURE OF RESPONSIBLE PARTY: _____

PRINT NAME OF RESPONSIBLE PARTY: _____Date_____