Financial Policy –*Dentistry by Jared French*

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with high quality dental care so that you can attain and maintain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy.

Payment is due at the time services are provided. We accept cash, checks, Visa, Mastercard, American Express, Discover and Care Credit. Returned checks will be subject to additional fees.

As a courtesy to you we will help you process your insurance claims. After payment is made for services rendered, you will receive reimbursement from your insurance company directly to you in the mail. Insurance companies have a wide variety of rules, plan limitations, and exclusions that no office can fully track. Dental insurance is a benefit for the patient provided by the employer and the contract lies between the patient, the employer and the insurance company. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into dispute with your insurance company over any claim.

Separated and Divorced couples with dependent children: It is the policy of this office to bill the parent that brings the children in for the dental treatment. Please make arrangements for payment from an ex-spouse before dental treatment is rendered if he or she will be paying. We can provide a treatment cost estimate before your scheduled appointment.

We require mobile and home telephone numbers if any, as well as a contact number to use in case of emergency. So please update us if your number changes.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies.

CONSENT: I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Signature (Patient or Responsible party) ____ Date______________