OAKWOOD HILLS
FAMILY DENTAL

FINANCIAL AGREEMENT

Thank you for choosing Oakwood Hills Family Dental. We are committed to providing the highest quality dental care and service. We will recommend and provide appropriate and necessary services without regard to the limitations imposed by insurance coverage. Our practice is "patient-centered' rather than "insurance-centered". The following is a statement of our Financial Policy, which we require you to read and sign.

Insurance

As a courtesy, we offer you an estimate for recommended treatment. All estimated patient portions are due at the time of service, unless we are a participating provider (in network) with your insurance. At any time, if you have questions regarding your dental plan as it relates to your treatment, we will be happy to try to answer them to the best of our knowledge. However, we encourage you to refer to your benefits manual or customer service if you have any questions about covered services. Please keep in mind your insurance is a contract between you and the insurance company. Your involvement in the process of providing us with proper information, and you being proactive in knowing your plan, will help maximize your benefits to their full potential. ***It is your responsibility to verify plan benefits for services with your insurance company.***

We will submit insurance claims on your behalf and will do all we can to help you collect legitimate claims. In the event that your insurance company is slow to pay or disallows the claim payment, the amount owed is your responsibility.

In order to file claims, we need the following information, most of which is provided on your insurance card or from your employer.

Insurance Company Name, Phone Number and Address for claims
Policy Holder Name and Date of Birth
Employer for the Policy Holder
Identification Number or Social Security Number
Effective Date of Policy

Our acceptance of insurance assignments does not absolve you of full responsibility for the treatment rendered. The **estimate** provided is to be considered a guideline until the final insurance payment is received and your account has been reconciled. The estimate is **not** a guarantee of insurance payment. If your plan has a reduced fee schedule or a provider network, it is **your** responsibility to be sure we are a participating (in network) provider.

Estimated Insurance Portion

Please understand that payment of your bill is considered a part of your treatment. The "estimated patient portion" will be due at time of service. To help make your payment more convenient, we have established the following payment options:

1. Cash, check or credit card - (Visa, MasterCard or Discover).
2. CareCredit, an outside financing for qualified patients. Ask for details at the practice.
3. For patients without dental insurance, a 5% savings is offered for pre-payment or full payment with cash or check at the time of treatment.

Over

Minor Patients

Minors, under the age of 18, must be accompanied by a parent or legal guardian at their initial visit and at all subsequent appointments, if at all possible. Should a recommended treatment plan change and the minor is here alone, we need approval from the parent or guardian before proceeding. Any changes in the minor's medical history needs to be reported to the office prior to treatment.

Divorce Decrees

This office is **not** a party to divorce decrees. The parent or legal guardian who accompanies the minor to the appointment is responsible for the charges. We **cannot** separate a minor's charges to be sent to each parent or guardian.

Returned Checks

There will be a $35.00 service fee applied to an account for any checks that are returned for any reason.

Missed appointments

We understand that at times it may be necessary to reschedule an appointment. If that need should arise, we request that you call the office at least 2 business days in advance of the appointment time. Should a pattern of missed appointments occur, future appointments may be impacted.

I have read, understand and abide by the terms stipulated in the above Financial Policy.

Print Patient Name	Patient/Guardian Signature	Date