Country Club Dental Care

Financial Policy

I ___________________________________, understand that, I am solely financially responsible for all treatment rendered to me, and charged to my account.

All dental services must be paid in full at the time that services are rendered.

As an insured patient,

- I understand that insurance is **not a "pay all"** it is merely an aide towards some dental treatments.
- I understand that I am **ultimately responsible** for all treatment rendered.
- I understand that I am responsible to know my dental benefits.
- I understand that as a courtesy to me, a general check of dental benefits will be done. This does not include details, clauses or limitations.
- I understand that as a courtesy, eligible dental services will be submitted on my behalf to my insurance company.
- I understand the **estimated** patient portion is due in full at the time of service.
- I understand the **estimated** patient portion is only an estimate based on the benefits previously checked and **not a guarantee of payment**.
- I understand that once a claim is processed any remaining balance is my responsibility to pay within 10 days of receiving a statement.
- I understand that any claim submitted and not paid within 45 days will automatically be billed to me and insurance will have to reimburse me.

A service charge of 1.5% per month (18% per year) on the unpaid balanced will be charged on all accounts with a balance exceeding 60 days, unless previously written financial arrangements are agreed upon.

I understand that the fees for dental care can only be extended for a period of 90 days from the date of consultation.

I understand that any balance older than 90 days will be forwarded to a **collection agency**.

Any returned checks will result in a $30.00 charge to your account in addition to the balance.

I have read the above conditions of treatment and payment and agree to their content.

Patient Name: ___________________________________DOB ______________ Relationship_________________

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Patient Name: ___________________________________DOB ______________ Relationship_________________

Signature of Responsible Party:_______________________________________ Date:__________________