Sample Financial Policy Statement

Payment for services, including deductibles and copayments, are due at the time of the service unless other arrangements have been made prior to treatment. Payments may be made using cash, check, or credit cards. Any arrangements for third-party financing must be made before starting treatment.

[IF your practice accepts dental benefit plans]: (Practice name) accepts most dental benefit plans. We are happy to submit the claims necessary to see that you receive your benefits. The insurance contract is an agreement between you and the insurance company. You are ultimately responsible for all charges. We cannot guarantee that any coverage estimated by your plan will be paid once a claim is filed.

In order to maximize your benefits and because plans differ from carrier to carrier, and from policy to policy, our office may refer you to your carrier or your employer's benefits coordinator for assistance in understanding your plan. Please note that dental insurance is intended to cover some but not all dental care costs, and not all services are covered by your plan. You are responsible for payment of all services regardless of the payable benefit.

Checks that are returned to our office from your financial institution are subject to a $____returned check fee*. This fee covers the processing fees that are charged to our office. We would be happy to discuss our charges and how they relate to your particular situation.

Please indicate your understanding and acceptance of these financial policies by signing below.

Patient's name _____Date_____

Patient, guardian or guarantor signature_____ Date_____

Witness_____Date_____

*Consult your state's applicable laws and regulations for limitations regarding fee limitations and restrictions.

This material is educational only, does not constitute legal advice, and may not satisfy applicable state law. Changes in applicable laws or regulations may require revision. Contact a qualified lawyer or professional for legal or professional advice.