Rose Family Dentistry

PAYMENT POLICY

We are pleased to offer our patients state of the art dentistry. We bill your dental benefits as a courtesy to you. However, if we have not received payment within 60 days from the date of service you will be financially responsible for the outstanding balance. Financial arrangements must be made in advance. Please remember that most dental benefits do not cover all dental costs. It is your responsibility to pay any deductible, co-pay, and/or any other balances not paid by your dental benefits.
A $25 charge will be assessed to all collection accounts, in addition to accrued interest. If your account is referred to our collection agency, interest will continue to accrue. In addition, you will be responsible for all added percentage based collection fees/costs per our collection company contract, attorney fees, court costs, service fees, associated misc. fees and costs.

Initial_____

MISSED APPOINTMENT POLICY

It is the goal of Rose Family Dentistry to provide the highest quality dental care to our patients. To best accomplish this, we request that all patients arrive for his or her appointments on time. By scheduling and not keeping your appointment, you are preventing other patients from being seen by the dentist. Although we make every effort to confirm appointments 2 days prior, it is your responsibility to keep track of your appointments. **There is a $25.00-$100.00 charge for failed appointments depending on time reserved without 24 hours notice.**

Initial_____

RETURN CHECK CHARGE

There is a $25.00 charge for all returned checks. We accept local checks with picture I.D. We accept most credit cards and cash.

Initial_____

PPO BENEFITS

We are a provider to many PPO plans. Members of these plans are required to pay for all estimated co-payments at the time services are rendered.

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PRIVATE BENEFITS

We work with all private benefit companies. We will estimate the patient portions according to the information given to us by the benefits company. The portion is due at the time services are rendered. Any unpaid balance is the patient's responsibility.

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NO DENTAL BENEFITS

Patients with no dental benefits will be responsible to pay for treatment the day services are provided.

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I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for the dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signature _____

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

Signature_____