Financial Policy

Thank you for choosing **Renwick Family Dentistry** as your dental care provider. As we enter this doctor-patient relationship, we agree to provide quality care at a fair and reasonable price, and you in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the coverage and benefits of your insurance plan. The following is a statement of our Financial Policy, which we want you to fully understand prior to treatment.

❖ Patients with no insurance will be charged according to usual and customary fees. It is your responsibility to inquire about fees before any treatment is rendered. Patients with emergency exams will be expected to pay before being seen. We accept cash, checks and most major credit cards. Full payment is due at time of service.

Regarding Insurance

❖ We may accept assignment of insurance benefits on your first visit to **Renwick Family Dentistry Practice**. This means that your insurance company will pay us instead of you ***however, your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they decide to pay.*** Before filing a claim on your behalf, we will attempt to verify your coverage and calculate your deductible and co-payments as accurately as possible. **ALL DEDUCTIBLES AND CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

❖You should be aware that your insurance company does not guarantee payment over the telephone. We will not know the exact amount they will pay until they respond to the claim. If after 60 days from the initial filing date, we do not obtain payment for services preformed, the balance will be transferred to you to be paid in full. **Since your insurance policy is a contract between you and your insurer, any disputes about payment must be resolved between you and your insurer.**

❖ As a new patient, you are required to have a comprehensive exam and either have vaild x-rays within the past year or have x-rays taken at our facility. ***Depending on your insurance coverage you may have already exceeded your limitations on certain procedures, such as comprehensive exams, cleanings or x-rays. In this event, please be aware that you are responsible for payment of all services rendered. The portions reflected on your treatment plan are an estimate of what we believe your insurance will cover. However, if your insurance company decides not to cover a particular procedure you remain fully responsible for payment of your bill.***

❖ Once payment is received on your claim, we will send you a bill for any balance remaining on your account. Payment is due upon receipt of your bill. After 30 days a 1.8% late fee will be applied to your account. After 45 days if payment has not been received your account will be sent to collections. Please avoid late fees and a negative reflection on your credit report by promptly remitting payment to our office.

❖ A $30.00 fee will be assessed for all checks returned for insufficient funds.

❖ Appointments that are no-showed or not canceled within 24 hours of the scheduled appointment time will be billed to the patient at a $30.00 charge.

I have read and understand the above Financial Policy.

By signing below, I acknowledge responsibility and agree to the terms as written above.

____________________________________ __________________

Signature of Responsible Party (Date)