Parkside Dental

Financial Policy for Our Patients

Our office wants all of our patients to be able to comfortably afford dental care, and we accept most major forms of payment so that our patients can have the opportunity to decide which payment option best suits their needs.

Payment is due in full at time of service.

- **If you have dental insurance:** As a service to you, we will file your insurance claim forms. Your insurance company will provide an estimate of what they may pay. *You will be responsible for the quoted co-pay in full at the time of your appointment*. Upon receipt of payment from the insurance company, we will bill you for any outstanding balance or refund any overpayment directly to you.
- **If you do not have dental insurance:** a 5% discount will be applied for payment made in full with cash or check.
- **Extended-term financing is available** through Care Credit, which is a health credit account that can be applied for through our office with an outside financing company. You may apply directly on their website at www.CareCredit.com
- We include a monthly billing charge or finance charge of 0.5% on all balances of 60 days and older.

Cancelation Policy

Late to Appointment: We strive to provide excellent care for all our patients. Appointment times are scheduled with this standard of care in mind. If you are unable to arrive within 10 minutes of the start of your appointment, we will ask that you reschedule in order to ensure there is sufficient time to provide you with the service you deserve.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we ask that you provide a courtesy notice at least 48-hours prior to the start time of your scheduled appointment.

In lieu of charging a cancelation fee, patients who accumulate 3 or more missed, late, or canceled appointments within a 12-month period will be charged a $100.00 non-refundable deposit in order to reserve additional appointment time.

- This deposit will be applied to any co-pay or payment due for treatment. Any overpayment will be refunded directly to the patient during the next billing cycle.
- Patients who fail to provide 48 hours' notice of cancelation, or arrive more than 10 minutes late for their appointment forfeit their deposit.

Revised 05-24-2022

The financial obligation for dental treatment is between you and our office, regardless of insurance coverage.

Because your dental benefits are governed by a contract between you/your employer and your insurance company, if we have not received payment from your insurance carrier 30 days after the claim is filed, the remaining balance will be due and payable by you.

The treatment we recommend is determined by what is best for your dental health. Our recommendations are based on your dental needs, not your insurance coverage. Your insurance company may or may not cover all recommended procedures. We request that you understand your benefit plan and be familiar with the dental benefits covered by your insurance in advance of your appointment so that together we can make the best treatment decisions. If you have any questions about your coverage, we encourage you to call your insurance company's Customer Service Center to learn more about your coverage.

Please remember that dental insurance is not designed to cover 100% of the cost of all treatment. For example, you may choose treatment that your dental insurance excludes from coverage (i.e., a "non-covered service"). In those cases, you will be responsible for the full amount of those services. Our staff is happy to provide you with estimates for the treatment options you have chosen, and answer any special concerns or questions that you may have.

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize release of my records to third party payers, other healthcare professionals or operations or other entities as deemed necessary by this office. I authorize the use of this signature for all insurance submissions. I authorize this office to charge my credit card or bank account for any unpaid balances, including but not limited to balances after insurance payment. I understand in certain circumstances, my credit report maybe requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand check payments may be converted to automatic bank drafts. I have received a copy of the Notices of Privacy Practices form.

I have read and understand all of the information contained on this form. I understand and agree that I am responsible for the balance on my account for any professional services rendered, without regard to whether I have insurance.

Patient Name (Please Print):_____ DOB: _____

Patient/Guardian Signature: _____ Date: _____