Dental Financial Guidelines

To create an understanding and partnership in the settlement of your account, No Surprises!

It is important to us that the quality of our business services matches the quality of our dentistry. We want the handling of your account, from the start through final payments to be perceived as an extension of the Dentistry care we provide you and your family. Please understand that payment of your bill is considered part of your treatment.

Patient's Role

As with any partnership, both parties have a role to play. Our role is to provide you with quality service. In turn, your role is to honor schedule appointment and pay for your treatment in a timely manner. Our team will work with you to determine financial arrangements that make sense for both of us. With an agreement made, our joint follow-through will result in a win for everyone.

In developing a financial arrangement it is important to remember your Dental future. Our experience has shown that when an account lingers, patients are likely to defer their appointments. It is discouraging to add new charges to an account when trying to pay off old charges. With this in mind, we will concentrate our efforts on clearing your account in as short a time as is comfortable for both of us.

We ask all patients to complete our Information and Insurance Form before seeing the doctor as that insures our office of obtaining the correct information to better serve you in regards to your Dental benefits.

We ask that the parent bringing a child to the practice be prepared with payment or co-payment at the time of treatment regardless of custody agreements.

What is your preferred method of payment at the time of service? _____

WE ACCEPT CASH, CHECKS OR MASTERCARD, VISA, Ask us about EASY PAY OPTION PLANS
WE OFFER ACCESS TO EXTENDED PAYMENT PLANS WITH CREDIT APPROVAL which I give my consent for a credit check.

Regarding your private payment

We may accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your complete insurance information. Remember that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid on your claim within 60 days, the full balance will automatically be transferred to you. That balance will be due upon billing.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

We very much appreciate your payment upon receipt of services. In the event that your insurance company denies payment of a service, you are responsible for that fee. Any unpaid balance after insurance pays is due within 60 days.

Please provide permission to process your credit card for any portion not covered by insurance or remaining balance not paid within 45 days after insurance payment is received.

Credit Card Number: _____ **Sec#**_____ **Exp. Date:** _____

Name on Card _____ **Signature** _____

I understand that any unpaid balance after 60 days is charged a yearly finance charge of 18%. I further understand that this finance charge is equal to 1.5% of my outstanding balance per month. **I understand that if my account reaches collection status (90 days) and I make no effort to pay off my account, my account will be assigned to a collection attorney or agency. If Crosspoint Dentistry or Dr. Kelly Truong must take additional steps to collect my account, I will pay ALL cost of collection, including court cost and attorney's fees incurred by Crosspoint Dentistry or Dr. Kelly Truong.**

Please Note: Returned checks will be subject to additional fees as well.

Thank you for reading our Financial Alliance. Please let us know if you have any questions or concerns.

I have read the Financial Alliance. I understand, accept, and agree to this Financial Alliance.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Witness for (Provider's Name) Date