

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Crosspoint Dentistry is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our FINANCIAL POLICY is important to our professional relationship. Please ask if you have any questions about our fees, FINANCIAL POLICY, or your responsibility. It is important to Crosspoint Dentistry that our patients can comfortably afford dental care. We proudly offer many options for you to decide which payment option is best for your needs.

- ❖ **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- ❖ **A DOWN PAYMENT OF HALF OF THE SERVICE SCHEDULED IS DUE AT THE TIME OF SCHEDULING AND THE REMAINING AMOUNT IS DUE THE DAY OF SERVICE.**
- ❖ **WE ACCEPT CASH, MASTER CARD, VISA, DISCOVER, AMERICAN EXPRESS, AND CARE CREDIT.**
- ❖ **Crosspoint Dentistry PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND NOT A GUARANTEE OF PAYMENT AMOUNT.**

#### **ADULT PATIENTS**

Adult patients are responsible for full payment at the time of service

#### **MINORS ACCOMPANIED BY AN ADULT**

The Adult accompanying a minor, his/her parents or guardians, are responsible for full payment at the time of service.

#### **UNACCOMPANIED MINORS**

The parents or guardians are responsible for full payment at the time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, Master Card, American Express, and Discover.

#### **INSURANCE**

Crosspoint Dentistry provides insurance company billing as a *courtesy* to our patients. The patient portion of the dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are **adjudicated by the insurance company**. In addition, certain insurance companies have annual limitations for dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Crosspoint Dentistry Staff regarding his/her remaining benefit in any such benefit period. The claims we submit to insurance companies indicate that you have assigned those benefits to Crosspoint Dentistry. However, if you are paid by the insurance company instead of Crosspoint Dentistry, you then become responsible for the total account balance and payment would be expected immediately. If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

**WE DO NOT ACCEPT MEDICAID/CHAMPUS/WORKERS COMPENSATION  
MOST MEDICARE PLANS REQUIRE THE PATIENT TO PAY FOR SERVICES AND SUBMIT THE RECEIPT TO THE INSURANCE  
COMPANY FOR REIMBURSEMENT**

#### **DELINQUENT PAYMENTS**

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. If the account goes into collections the patient is responsible for all lawyer and collection fees. In addition, all payments returned due to non-sufficient funds will be subject to an NSF fee of \$37.00 dollars.

#### **APPOINTMENTS**

We reserve time specifically for you, it is vital that we receive appropriate notice for cancellations. If you find that you are unable to keep an appointment, please call our office at least 48 hours, no-show/cancellations outside of 48 business hours will be charged a fee of \$50.00 for the missed appointment. For larger, more extensive appointments. We understand circumstances may arise but if an appointment for larger cases is cancelled or not rescheduled unfortunately the 20% cannot be returned. Due to the expenses we acquire in preparing for larger cases and the financial burden on the practice.

**Thank you for understanding and accepting our FINANCIAL POLICY. Please let us know if you have any questions or concerns!**

Patient/Guardian \_\_\_\_\_ Date \_\_\_\_\_

# 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