FINANCIAL POLICY

In order to address our patients' questions about our financial policy and to aid patients in completing dental treatment, we offer the following payment options.

We accept Cash, Check, Discover, Visa and MasterCard for your convenience.

We will be happy to assist you by filing your dental insurance claims, however, payment is expected on any unpaid balance(s) after 45 days.

Single appointment treatments:

To reduce the expense of bookkeeping and billing costs, we ask your cooperation in paying for services that can be completed in one appointment on the day of that appointment. This includes periodic examinations, cleanings, and minor dental treatment. Patients with dental insurance will be asked to pay an estimate of their portion. To avoid increased fees to all patients, a monthly billing charge of $4.00 or an annual interest rate of 12 percent per anum, whichever is greater, will be added to any account without a written financial agreement.

Prosthetics: (dentures, partial dentures, etc.)

All removable prosthetics must be paid for in full by the date of delivery. Half of the fee must be paid on the date of the initial impression.

Refund:

Patients, who pay in full for treatment totaling more than $200.00 prior to their first treatment appointment, will be refunded our bookkeeping and billing cost. This saving represents 5 percent of the total fee.

Extended Credit:

If you would like our office to extend credit for more than $200.00, we also offer a payment plan option made within the guidelines of the Uniform Consumer Credit Code. Any treatment requiring three or more payments must have a written financial agreement. We will cooperate with you to minimize any undue financial hardship in your budget. In the use of this option, we request your cooperation in the following:

A. A financial agreement must be signed and initial payment made before your first appointment for treatment.

B. Payments need to be made promptly on or before the day of the month you select.

C. Payments less than the agreed amount will be rejected.

D. The minimum monthly payment must be at least 10% of the original total balance but not less than $60.00 per month.

E. We will not charge interest for this courtesy for eight months. Any balance remaining after eight months will be subject to service and interest charges. Service charges will also be applied to late payments.

Credit Agreement:

I/We agree to pay collection costs and/or reasonable attorney's fees if any delinquent balance is placed with an agency or attorney for collection or suit.

Name of Patient_____Date_____

Responsible Party_____

ASSIGNMENT OF DENTAL BENEFITS

Please understand we will do all that we can to see that your insurance company fulfills their responsibilities on your claims, however, your insurance company has a legal contract with you and not with us. Therefore, many insurance companies refuse to deal with us except for claim processing.

Two options are available to those with dental insurance:

1. Your total dental insurance reimburses you directly for dental charges and you are billed as though you had no dental insurance.

2. As a courtesy to you, we will bill your insurance company and wait 45 days for them to respond with their portion before adding it to the amount due by you.

If you choose option 2, please sign below.

I hereby authorize payment of dental benefits otherwise payable to me directly to Kevin J. Reece, D.D.S.

Insured:_____Date_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
(*You May Refuse to Sign This Acknowledgement*)

I, _____, have received a copy of the Notice of

Privacy Practices for Dr. Kevin J. Reece's office. **(Please Print)** Date_____

AUTHORITY FOR COMMUNICATION ACCORDING TO THE PROTECTED INFORMATION ACT

Yes ☐ No ☐ I give this office permission to confirm Dental appointments by either of the following:

1. Calling
2. Sending Reminder Card
3. Leaving message
4. Rescheduling missed appointments

Initial:_____Date:_____