Financial Policy

1. Payment is due at the time services are rendered. We accept cash, checks and credit cards (MasterCard or Visa).

2. For new patient emergency visits we require payment in full at the time of the appointment.

3. As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for our reimbursement, or you may assign the payment to our office, and we will file the insurance for you. The office will accept assignment for only the primary insurance coverage.

4. Our office will file your insurance a maximum of two times per appointment.

5. If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility. We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.

6. You must provide the office with a dental insurance card with the proper mailing address of the insurance company. If you fail to bring your card to your appointment, you will be responsible for payment at the time of service, and we will provide you with a claim form to submit for reimbursement.

7. If insurance benefits are assigned to our office, you are responsible for paying your deductible and co-pays at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. The amount of coverage you receive depends on the insurance plan, not the doctor's fees.

8. The office cannot carry balances longer than 90 days, regardless if the insurance payment is still pending. A $5.00 monthly re-billing fee will be added to your account if not paid within 60 days, regardless of the amount of the balance.

9. After 90 days, we will inform you of the delinquent account by mail, and if no action is taken to clear the account, your account will be sent to our collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.

10. There will be a $30.00 service charge for all returned checks.

11. The parent or guardian who brings the child for their initial visit is responsible for payment, independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

Authorization

1. I authorize Swanson Family Dental PC and staff to release any information concerning my case to my insurance company.

2. I have read and accept the above Financial Policy, understand it, and agree to the terms above regarding payment.

X_____

Printed name of patient /or responsible party

X_____ **Date**_____

Signature of patient /or responsible party