

JONATHAN CUTHRELL D.D.S., P.A.

Financial Policy

Thank you for choosing our office to care for your dental health. Our office has several financial options to make you financially comfortable as you make important decisions about your oral health. Our goal, and we hope yours, is to make sure you keep all of your teeth for all of your life in maximum comfort, health, and function—and of course, we want your smile to look great throughout your life!

Please read this document carefully. We would like for you to feel free to ask any of our office staff if you have any questions regarding your financial responsibilities.

Payment in full is due at the time dental treatment is provided unless previous arrangements have been made. We will gladly file your primary dental insurance for you and allow your insurance company to pay us directly. We accept cash, personal check, MasterCard, Visa, American Express, and Discover. If your treatment requires several visits, you will be given an estimate of our fees, and our staff will discuss and make financial arrangements prior to the appointments.

- ❖ On individual services over \$500, a 5% bookkeeping credit (discount) will be given when treatment is paid in full by cash or check on or before the date of service.
- ❖ **Mastercard, Visa, American Express, or Discover:** We gladly accept Mastercard, Visa, American Express, and Discover. However, due to the fees charged by these agencies, when a personal credit card or debit card is selected no bookkeeping credits (discounts) will be offered.
- ❖ **Finance Your Dental Treatment for up to 12 months Interest-Free by using CareCredit:** Allow your needed care to be provided in a timely manner and still allow you to remain financially comfortable. This option is available for patients who qualify, and is available for dental procedures ranging from \$300 - \$25,000. These procedures can even include cosmetic and comprehensive restorative dentistry. No pre-pay discounts apply.
- ❖ **Prepaid deposit plan:** Our office is happy to accept advance deposits for future treatment. For procedures involving lab work i.e. crowns, partials, and dentures, the minimum amount which must be paid before work can begin will be the estimated lab fees.

Monthly Statement: Our billing statement will show:

- ❖ Total Balance
- ❖ Patient Portion of total balance
- ❖ Insurance balance outstanding
- ❖ Balance Forward
- ❖ Any payment or treatment activity on your account in last 30 days.

Dental Insurance

At a time when many offices are no longer accepting insurance assignment, as a courtesy to you, we **will gladly file your primary dental insurance for you and allow your insurance company to pay us directly.** We will make every effort to accurately estimate what your specific insurance policy will pay for all treatment received. **We ask that you be prepared to**

pay your portion of all charges at the time of service, unless arrangements have been made prior to your dental appointment.

- ❖ Please keep us informed of **any insurance changes** such as policy name, insurance company address, or a change of employment.
- ❖ Dental benefits are not determined by the dentist.
- ❖ **Please note that your insurance is a contract between you and your insurance company. We are not a party to this contract.** Although we will **estimate** what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and amount paid. **We are not in-network providers with any insurance plan.**
- ❖ If your insurance has not paid after 45 days beyond your treatment date, we ask that you pay the total balance. We will always be available to assist you in collecting from your insurance company all that is due to you under the terms of your policy.
- ❖ If your insurance company pays more than the balance due, **we will gladly issue you a refund upon request or the amount may remain as a credit on your account,** whichever you choose.

Minor Patients

The adult/parent accompanying the minor is responsible for payment of the minor patient's account, regardless of who the insurance holder is. For unaccompanied minors, non-emergency treatment will be denied unless the minor is prepared to pay when services are rendered.

This is an agreement between Phillips & Cuthrell, D.D.S., P.A., and you, our patient. By signing this agreement, you are agreeing to pay for all services that are received.

Patient's name: _____

Responsible party (if not patient): _____

Signature: _____

Date: _____