APEX DENTAL CARE

FINANCIAL POLICY

In our continued efforts to provide you with the best dental care possible and to provide those services at reasonable rates, we are pleased to offer the following methods of payment:

1. Cash or Check (with a valid drivers license)
2. Visa, MasterCard, Discover, American Express
3. Extended payment plan through a dental finance company (OAC)

PATIENT LIABILITY

- Entire cost of dental treatment
- Deductibles
- Co-pays
- Any other self-pay portions

As a courtesy, we bill your insurance after coverage has been verified. However, co-pays, deductibles and co-insurance amounts are due at the time of treatment. It is the patient's responsibility to know what their insurance does and does not cover. Due to the rising costs of bookkeeping we cannot accept dual insurance payments. As a courtesy we will bill both your primary and secondary insurance plans. However, you will be responsible for your primary insurance co-payments at the time of service. The entire bill is the patient's responsibility. Any overpayment will be promptly refunded. *You may opt to have your secondary carrier assign benefits to you directly.

We are happy to accept assignment of insurance benefits. If your insurance company does not pay the balance of your bill within 90 days, the amount will be billed to you, due upon receipt. You may then pursue payment from your insurance company. Insurance is a contract between you, your insurance company and your employer.

If you have any question regarding your bill, please ask now or call our office at 480-813-8280

I have read, understand and agree to the above Financial Policy. I am aware that I am fully responsible for all costs not covered by insurance. In the event that payment is not made on this account and it is placed with a licensed collection agency, I/We agree to pay the fees of the collection agency equal to a maximum of 50% of our outstanding balance at the time the account is place with the agency. Interest of 10% per year will be accrued on the principal balance. Should legal action also be necessary to collect the account, I/We agree to pay attorney's fees and court costs incurred for collection.

Patient Name______________________________ Date_____________

Responsible Party__________________________ Date_____________