PAYMENT POLICY ACKNOWLEDGEMENT

FINANCIAL AGREEMENT

We are committed to providing you with the best possible dental care. Our fees are representative of the usual and customary charges for our area. If you have dental insurance, we assist you in any way we reasonable can to help get your claims paid. In order to achieve these goals we need your assistance and your understanding of our payment policy.

It is important that you realize, however, that…

1. Your dental benefit contract is between you, your employer, and the insurance company. We are not a party to that contract. This office files your insurance as a ***courtesy to you***, but it is not obligated to do so. Regardless, you agree to pay any services that are not covered by your insurance company. This includes, but is not limited to, coinsurance, deductibles, non covered benefits due to policy limits or policy exclusions as well as failure to comply with your insurance plan requirements.
2. Proof of insurance. All patients must complete our patient information form. We must obtain a copy of your current, valid insurance card and a driver's license.
3. Insurance companies require the date of birth ***and*** social security number of the subscriber. Please make sure that information is listed on your patient history form.
4. Not all dental services are a covered benefit in all contracts.
5. You (not the insurance company) are responsible to us for all of our fees for services rendered to you.
6. For patients who have insurance an ***ESTIMATE*** will be given of the benefits that the insurance company is expected to pay, and any estimate is expected at the time services are rendered.

For the convenience of our patient, we offer the following methods of payment:

- Payment in full by cash, check, bank card or alternate financing for each appointment as service is rendered.
- For insurance patients we will accept payment for the initial examination directly from the insurance company for that percentage the company will cover. We gladly accept insurance assignments, but require that the deductible and non- covered fees be paid at each visit. In the event of a duplicate payment, you will be reimbursed or your account credited.
- Bank charge cards - Visa, Discover & MasterCard are accepted.
- Alternate financing (CareCredit) accounts are gladly accepted. We will be glad to assist you in filling out an application. Credit approval is required.
- Major services: Appliances, crowns, bridge partials and dentures. Payment of ½ at the initial appointment and the balance ***must be paid in full upon delivery.***

Southwest Dental Group, Robert D. Schick, D.D.S.
1007 West Oak Ave, Duncan, OK 73533
580-255-6621

Non-Payment

If your account is 90 days past due, you will receive a letter stating you have ***10 days to pay your account in full.*** Partial payments will not be accepted unless otherwise negotiated. Please be aware if a balance remains unpaid, we may refer your account to a collection agency and/or report to the credit bureau. You and your immediate family member may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternate dental care. During that 30 day period, our dentist will only be able to treat you on an emergency basis.

**Please be aware that any parent bringing a child to our office is legally responsible for payment of ALL services rendered.*

Missed Appointments

****Please give 24 hours notice of cancellation or charges may be your responsibility.****

We will gladly discuss your proposed dental treatment and answer any questions you might have as to the involvement of your dental benefit program in receiving this care. We appreciate the opportunity to serve you.

I, the undersigned, as the patient or legal agent of the patient, hereby certify that I have read, and fully and completely understand the payment policy acknowledgement for dental treatment and that I have signed the payment policy acknowledgement knowingly, freely, voluntarily and agree to be bound by its terms.

Patient/Authorized Representative Signature:	Witness Signature and Title:
X_____	X_____
Date: _____	Additional Witness Signature and Title:
Relationship to patient:	_____
_____	(Patient was unable to sign or refused to sign)

Southwest Dental Group, Robert D. Schick, D.D.S.
1007 West Oak Ave, Duncan, OK 73533
580-255-6621