FAMILY DENTAL
FELLOWS

Thank you for allowing us to provide your dental care.
We are committed to give you and your family the best treatment available.
Please understand that payment of your bill is considered part of your treatment.
The following is a statement of our Financial Policy, which we require that you read, agree to,
and sign prior to any treatment.

METHODS OF PAYMENT: ***If any financial arrangements are provided by the office, there will be a 3 month maximum.***
If the account goes **90 days** without payment it will be sent to **collections or small claims court** (with additional filing fees) automatically. There will be no exceptions.

Payment options:

1) Cash / Check (including post dated checks)
2) Credit Card (Visa, MasterCard, American Express)
3) Care Credit, a special lending institution for dental purposes, see Melinda for more information.

PATIENTS WITH INSURANCE COVERAGE: If you have dental insurance, we are happy to submit the charges for service to your insurance company as a courtesy to you. Our goal is to provide you with all the information we can obtain about your benefits.
You are responsible for all charges to your account regardless of your insurance rates.

- We will make every effort to maximize your insurance saving you the most 'out of pocket' costs we can. We will gladly discuss your proposed treatment and answer any questions relating to your insurance benefits. Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate. Insurance companies change their fees and benefits frequently, making it is impossible for us to keep up with all this information. In order to achieve these goals we need your assistance to provide all insurance information at the initial visit and continue to provide any updated information.
- Any treatment plans we render are *estimates* only and are no guarantee of payment until the actual insurance payment has been made.
- We will need to collect any co-pay or deductible plus the estimated out of pocket, on the day of treatment. Any procedures that have lab costs will require 50 % down on the day treatment is started.

PATIENTS WITHOUT INSURANCE COVERAGE:

- For our new patients without dental insurance we require $120 on your first appointment. We then can make further arrangements for the remainder of the balance.
- Any procedures that have lab costs will require 50 % down on the day treatment is started.
- We offer a 5% discount for payment in full at the time of service. For our senior patients the discount is 10%.

FINANCE CHARGE: A finance charge of 19% will be added to all open accounts after 90 days. A fee of $25.00 is applied to all checks returned by the bank.

MISSED APPOINTMENTS:

- There will be a missed appointment fee of $25.00 charged to all patients that fail to keep their scheduled appointment or do not cancel 24 hours in advance. This appointment time is reserved especially for you. Dr. Fellows is very busy and has a waiting list, if you give advanced notice we can call someone that has been waiting. This fee is one we hope to never charge out, and are confident you will be most responsible in keeping your commitment to Dr. Fellows.

DIVORCE DECREES / MINOR PATIENTS:

- This office is not party to your divorce decree. The financial responsibility for children involved rests with the accompanying adult.
- The adult accompanying a minor is responsible for payment at the time of treatment. Unaccompanied minors will be denied non-emergency treatment unless pre-authorized by a parent/guardian. Payment is still expected at the time of service.

Thank you for trusting us with your care. We will do all we can to make your dental and financial treatment a good experience. We are committed to provide you and your family with the best dental care available. If you have any questions about payment options or financial responsibilities please ask for Melinda and she will take care of you.

I have read and fully understand that I am responsible for my financial obligation to Fellows Family Dental.

Full Name:_____Date_____