WELCOME TO APEX DENTAL CENTER
Office Policy

THANK YOU FOR CHOOSING OUR OFFICE FOR YOUR DENTAL CARE. THE FOLLOWING IS A STATEMENT OF OUR FINANCIAL POLICY, PLEASE REVIEW AND SIGN BEORE TREATMENT.

INSURANCE COVERAGE AND PAYMENTS:

1) YOUR DENTAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE CARRIER IT IS YOUR RESPONSIBILITY TO KNOW THE TERMS CONTAINED IN YOUR POLICY REGARDING COVERAGE, DEDUCTIBLES AND NON-COVERED SERVICES.

2) IF YOU HAVE ANY QUESTIONS ABOUT YOUR INSURANCE YOU WILL NEED TO CONTACT YOUR CARRIER DIRECTLY WE DO OUR BEST TO ESTIMATE FEES DUE FROM THE INSURANCE COMPANIES WHEN SERVICES ARE RENDERED ALL DEDUCTIBLES AND FEES NOT COVERED BY YOUR INSURANCE FOR SERVICES RECEIVED HERE WILL BE THE PATIENT'S RESPONSIBILITY AND IS DUE AT THE TIME OF SERVICE.

3) IF YOUR ACCOUNT HAS AN OUTSTANDING BALANCE YOU WILL BE EXPECTED TO PAY BEFORE SEEING THE PROVIDER.

4) WE ACCEPT PAYMENT FROM MOST INSURANCE CARRIERS AND WE WILL FILE YOUR INSURANCE CLAIM FOR YOU THEY MAY PAY US DIRECTLY, HOWEVER, THE PATIENT NOT THE INSURANCE COMPANY IS ULTIMATELY RESPONSIBLE FOR THE PAYMENT TO THIS OFFICE WE CANNOT ACCEPT RESPONSIBILITY FOR COLLECTING DISPUTED INSURANCE CLAIMS OR NEGOTIATING SETTLEMENT ON A DISPUTED CLAIM.

5) IF WE ARE UNABLE TO VERIFY YOUR INSURANCE YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME SERVICES ARE RENDERED.

6) OUR OFFICE ASKS THAT AT LEAST ONE PARENT COMES IN WITH THEIR CHILDREN TO SEE THE DOCTOR WHEN THEY ARE BEING TREATED IF PATIENT IS A MINOR (UNDER 18). WE ALSO ASK THAT OTHER FAMILY MEMBERS WAIT IN THE WAITING ROOM WHILE PATIENT IS BEING TREATED THIS ALLOWS OUR STAFF TO WORK MORE EFFICIENTLY.

7) FOR YOUR CONVIENCE WE ACCEPT CASH, PERSONAL CHECKS, VISA, MASTERCARD AND CARECREDIT.

8) YOU WILL BE CHARGED A $ 25 FEE FOR ANY BROKEN APPOINTMENTS/NO SHOWS AND ALL CANCELLATIONS SHOULD BE MADE LESS THAN 24 HOURS PRIOR TO APPOINTMENT ALL RETURNED CHECKS WILL BE ASSESSED A $35 CHARGE PER RETURNED ITEM.

I UNDERSTAND THE FINANCIAL POLICY OF ***APEX DENTAL CENTER***, THAT I WILL BE FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED NOT COVERED BY MY INSURANCE COMPANY.

NAME OF PATIENTS_____

SIGNATURE_____Date_____