FINANCIAL POLICY
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Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of Our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our health history and insurance form before seeing the dentist.

FULL PAYMENT IS DUE AT TIME OF SERVICE.

WE ACCEPT CASH, CHECKS OR VISA/MASTERCARD

IF YOU DO NOT HAVE INSURANCE, PAYMENT IN FULL IS EXPECTED AT THE TIME OF SERVICE, UNLESS YOU HAVE MADE OTHER ARRANGEMENTS WITH OUR OFFICE.

THERE WILL BE A $40.00 FEE FOR ALL RETURNED CHECKS

We are NOT a PPO-HMO provider, which means that if your insurance company requires you to see an in network Provider, it will not pay for our visit. Please let us know if this is your situation. Co-Pays and deductibles should be paid at the time of service, as required by your insurance company.

Regarding Indemnity Insurance

We may accept assignment of insurance benefits, but you are responsible for the bill regardless if the insurance company pays or not. You must give us complete and correct insurance information, in order for us to properly submit claims for you. If we do not have correct insurance information at time of service you will be responsible for payment in full. When you have properly notified us of the correct insurance information, then we can submit the claims to the insurance company.

It is the Law in the state of Ohio that all insurance companies pay the claims in a timely fashion of **30 days or less.** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your dental Insurance policy. ______**INITIAL**

Collections/Bankruptcy-If any of these occur the patient will no longer be able to return to the practice.
There will be a $13.00 processing fee added to your account if it is turned over to our collection agency. The responsibility for payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court order responsibility judgement must be determined between the individuals involved without with inclusion of our office. ______**INITIAL**

PLEASE BE SURE TO SUPPLY THE STAFF WITH ACCUATE INFORMATION REGARDING GUARANTOR, ADDRESS, TELEPHONE NUMBER AND INSURANCE AND A COPY OF YOUR INSURANCE CARD.

Accounts that are 90 days past due, could be subject to collection action and fees unless arrangements have been made with our office. Any account turned over to collection would cause a breech in the physician/patient relationship, resulting in discharge from this office. _____**INITIAL**

MISSED APPOINTMENTS

Unless canceled, at **least 24 hours** in advance, our policy is to charge **for missed appointments** at the rate of **$70.00.** Please help us serve you better by keeping scheduled appointments. _____**INITIAL**

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy.

I authorize my insurance benefits to be paid directly to Erin A. Knierim, D.M.D., M.S.

I authorize Erin A. Knierim D.M.D., M.S. to release pertinent medical/dental information to my insurance company as requested or to facilitate payment of a claim.

X________________________________ _________ X___________________________ ________

Signature of Patient or Responsible Party **Date** **Signature of Co-Responsible Party** **Date**