ROCKPORT FAMILY DENTAL

227 MAIN STREET; ROCKPORT, MA 01966

Financial Policy Pg.1

1. **Payments**: Payment is due on day of service. Payment options are cash, debit card, checks (established patients only) or credit card (VISA, MasterCard, Discover or American Express). For financing larger treatments, we also offer Care Credit. _____ (Initial)

2. **Dental Insurance**: Insurance is a contract between you and your insurance. There is no direct relationship between Rockport Family Dental and your insurance company. Benefits are determined by the plan selected by you and/or your employer and we are not a party to this contract. The terms of your contract, methods of reimbursement, and determination of your benefits are defined by your insurance company and not Rockport Family Dental. We will file your dental insurance claims as a courtesy to you. We do not guarantee payments and are not responsible for providing you with the plan limitations, exclusions, and provisions determined by your insurance company. You agree to pay your portion of the charges covered, or not covered (denied) by your insurance. _____ (Initial)

3. **Deposits**: To book an appointment for major services that require one or more hours, 50% of the total cost of the proposed procedures (or 50% of **estimated** portion not covered by insurance) must be collected. The remaining is due on day of service. _____ (Initial)

4. **Cancellation/Broken Appointment**: 48 hour notice of cancellation is required for all major procedures (crowns, root canals, dentures, and implants). 24 hour notice of cancellation is required for all other procedures (cleaning, filling, follow up). A cancellation fee may be charged. Patients with 3 missed appointments will not be reappointed and asked to transfer their records to another dentist. _____ (Initial)

5. **Finance Charge**: A finance charge will be added to your account for any balance that remains unpaid after 30 days after receipt of notice. This charge will be assessed monthly, until the remaining balance is paid in full. _____ (Initial)

6. **Monthly Statement**: If you have a balance on your account, we will send you a monthly statement. Billing fees may be charged. It will show the previous balance, any new charges made to the account, finance charges (if applicable), and any payment or credit applied to your account during the month. Professional fees are the responsibility of the patient or guardian authorizing treatment. We cannot send statements to other persons. _____ (initial)

7. **Past Due Accounts**: If your account is past due, we will take necessary steps to collect this debt. We will refer your account to a **collection agency** after 3 attempts to collect this debt. If no payment arrangements have been made by then, we will turn over the account and you agree to pay the collections costs which are incurred. _____ (Initial)

8. **Effective Date**: Once you sign this agreement, you agree to all terms and conditions herein and the agreement will be in full force and effect. This agreement is between your treating dentists: Craig P. Hornung DMD or one of his dental associates and the patient/parent/debtor named on this form. Continued In this agreement, the words "you", "your", and "yours" means the patient/debtor. The word "account", means the account that has been established in the

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Patient's/debtor's name to which charges are made and payments are credited. The words "we", "us" and "ours" refers to your treating dentist; Craig P. Hornung DMD or one of his dental associates at Rockport Family Dental. _____Initial

By executing this agreement, you agree to the terms of the financial agreement and agree to pay for all services that are received.

_____ _____

Patient's Name (Print) Patient's Name (signed)

_____ _____

Responsible Party (Print) Responsible Party (signed)

_____

Date