Arizona Periodontal Group Financial Policy

1. It is our policy to make definite and clear financial arrangements prior to beginning any treatment. We are in network and/or a participating provider with some insurance companies not all of them. We will help you to maximize your dental benefits in our office. Please bring your insurance card with you at the initial exam!

2. Our fees are reasonable and customary for quality care in this area, but as different insurance companies use different fee schedules (which vary greatly), we may or may not fall within what they consider to be usual and customary. You are responsible for paying all charges not covered by your insurance company.

3. Please remember that insurance is a contract between you and the insurance company. Despite verification by phone or written pre-authorization, your carrier may still deny payment on a claim.

4. We accept Cash, Check, Debit, Visa, Mastercard, Discover, American Express, and Care Credit. There is a $50.00 returned check fee.

5. Often times patients find it to be convenient for them to keep a credit card on file for balances over 60 days to be charged to. Is this something you would like to do? **YES / NO**. If yes, please provide CC# and Expiration Date________________________________

6. We have a 24-hour cancellation policy. We reserve the right to charge a fee of $75 per hour scheduled if less than 24 hours notice is given.

7. In the event that an account becomes delinquent, you will be responsible for all legal and administrative fees involved in collecting monies owed.

8. The parent or guardian who brings a child for an appointment is responsible for paying the patient portion and any prior balance at that visit.

By signing below I acknowledge:

1. I have read, understand and accept all conditions of this financial policy.

2. I certify that I have insurance coverage if indicated above, and assign directly to Arizona Periodontal Group, LLC all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by my insurance. I understand the office will assist with insurance submissions. I hereby authorize Arizona Periodontal Group, LLC to release all information necessary to secure the payment of benefits. I also authorize the use of this signature on all insurance forms.

3. I authorize Arizona Periodontal Group, LLC to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also authorize release of any information, including diagnosis and the records of any treatment or examinations rendered to my dependent or me during the period of such care to third party payors and/or health practitioners.

If opted, I authorize Arizona Periodontal Group, LLC to charge balances over 60 days to the credit card on file that I have provided above.

Signature______________________________ Date _____________

Print Name _________________________________

Business Assistant ______________________________