Financial Policy

Thank you for choosing us for your dental health care. Your dental health is our first priority and we are committed to successful dental treatments for you and your family. It is our belief that patients should make informed decisions about their dental health care. Proper financial arrangements are vital to our success in delivering top quality dental care. The following is a statement of our financial policy, which **we require you read and sign prior to any treatment.**

Financial Policy

Prior to initiating any treatment, we will inform you of your financial status with our office. This will include providing you with an estimate of the cost of your treatment. When a significant amount of work is planned, we will provide you with a typewritten estimate, which will also include the amount we **anticipate** you insurance company will assist with. We invite you to call our office or stop by with any questions that you might have.

We wish to schedule your treatment at a pace that is financially comfortable to you. Occasionally, patients will request that work be spread out over months or even years. While this is acceptable in many cases, be aware that your oral health can change significantly in a relatively short amount of time. Therefore, regular comprehensive examinations (with x-rays as needed) will be performed.

Please take a moment to review the current financial options available through our office. Should you need assistance with financial options at any time, our team will be available to assist upon your request.

Payment Options

1. Payment in full is due on the day of each visit. To demonstrate our appreciation for patients who are prompt with full payment, we will extend a three percent (3%) reduction in the total fee when payment is received in the form of cash or check.
2. Payments may be available for treatment and patients who qualify
3. We require that all insurance co-pays be paid at time of service. As a courtesy, we will bill your insurance for services rendered. To do so, we must receive an updated copy of your insurance card at your first appointment. If necessary, we will submit a pre-determination of benefits request to your insurance carrier prior to treatment. This allows us to obtain an estimate of your dental benefits and an estimated amount your dental plan expects you to be responsible for. **While we help you in every way possible to obtain your maximum allowable insurance benefit, the insurance contract is between you (the insured) and your insurance company, and does not replace your responsibility for your account with us. Billing your insurance is done as a courtesy. Knowing your insurance benefits and any balance not paid by the insurance company remains your responsibility.**
4. Secondary Insurance: Having more than one insurer **DOES NOT** necessarily mean that your services are covered 100%. We will gladly bill your secondary carrier. **Any balance not paid by your secondary insurance carrier remains your responsibility.**
5. For all appointments after 01 MAY 2020, there will be an additional $15 fee to cover increased requirements for Personal Protective Equipment and safety measures per OSHA and CDC guidance. This will be billed to your insurance and may be covered on an individual insurance and paid plan basis. Any non-covered expenses will be patient's financial responsibility.

Please remember that we are not a lending institution and any account that is 90 days past due from the original date of service will incur an eighteen percent (18%) annual interest rate.

A fee of fifity dollars ($50) will be charged for short notice cancellations (less than 24 hours) and missed appointments.
A thirty-five dollar ($35) fee will be charged for all returned checks.

Usual and Customary Rates

We are committed to delivering the best quality dental treatment for our patients, and we charge what is usual and customary for our area.

I hereby authorize release of any information to my insurance carrier regarding my treatment. I also hereby authorize any insurance benefits otherwise payable to me to be paid directly to Beck Passamano Dental Group for services provided. By signing below, I acknowledge that I have read, understand, and agree to the terms of this Financial Policy. This agreement stays in force until I change it is writing.

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Name of Patient or Responsible Party (Please Print)

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Signature of Patient or Responsible Party (for digital forms your printed name acts as your signature) Date