PATIENT FINANCIAL AGREEMENT

GARY SICKLES D.D.S. **rev: September 2013**

Statement: It is our responsibility and primary goal to provide quality oral health care for our patients with the best possible treatment in a safe environment. We use high quality supplies and materials. In the interest of good practice we have established a financial policy. An effective financial policy enables the provider and the patient to avoid misunderstandings. Often the goals of Insurance companies are to treat patients in the least expensive manner, and not necessarily the most effective and customized way for an individual patient needs. We provide our patients with the finest treatment available and base our treatment recommendations on what would be best for you or your child rather than what your insurance company will not pay.

Agreement:

- Please review the outline of benefits of your policy prior to scheduling treatment. **We encourage all patients to become familiar with their dental plan to prevent disappointments with insurance payment or reimbursements. You are fully responsible for all fees regardless of your insurance coverage.**
- **Gary Sickles D.D.S.** will bill your supplied insurance carrier. As agreed, we will accept contractual allowances for treatment. Your *estimated* co-pay on the day of service is always appreciated. We cannot accept responsibility for negotiating a disputed claim and allow a maximum of 90-days for your insurance company to clear account balances. If your insurance does not pay within 90 days of the treatment rendered, we shall expect payment in full from you. *Please review the Delinquent Accounts section below for additional information.*

- As a courtesy to our patients, we will electronically submit all insurance forms for you. Most insurance companies will respond within four to six weeks. If your statement does not reflect your insurance payment within that time frame, please contact our office.

- **We have extended a 90 day policy for your remaining patient payment responsibility to be paid in full. Ninety days starts from the date of service for each procedure.**

No Insurance:
Patients who have no insurance will be required to pay in full on the day of treatment. As a service to our patients we are pleased to offer **Care-Credit** card (dental credit card), North America's leading patient payment program. Please ask our patient coordinator for an application. We also accept **Cash, Check, Visa, MasterCard and Discover.**

Returned Check:
A $35.00 fee will be applied for any check returned for insufficient funds.

Accounting Reduction:
On treatment for services over $500.00 we will apply an accounting reduction of **10%** if paying by cash, or 5% if paying by credit card on the date of service.

Senior Citizen Discount:
For our patients beginning at 65 years of age our office will apply a **10%** discount on patient balances.

Delinquent Accounts:
Should your account become delinquent it will be turned to collections. Once this occurs, all future appointments for ALL patients under the account will be canceled and ALL communications need to be through Mid-Continent Credit Services.

By signing below, I agree that I have read and understand these terms. I also acknowledge receiving a copy of this agreement. We look forward to beginning a wonderful relationship with you and/or your child. Please do not hesitate to call, we will be happy to assist you.

Patient Acknowledgement:

Signed:_____

Date: _____