DISTRICTDENTAL

FINANCIAL POLICY

Thank you for selecting District Dental for your dental care. In order to prevent any misunderstanding over the responsibility of payment for surgical services provided to our patients, we supply you with the following information:

The patient, guarantor or the person bringing the patient (if the patient is a minor), is responsible for payment of any balance due following the office visit, test or procedure. We accept cash and credit cards (American Express, Discover, MasterCard, Visa and CareCredit). In the case of divorce parents, the parent bringing the child to the office is responsible for payment of any balance due at the time of service. Should you need documentation to secure reimbursement, a copy of the bill is furnished at each visit.

If a referral from your primary dentist is required by your insurance plan, it must be received in our office by the appointment time. If we have not received the referral by the time of your arrival, your appointment will be rescheduled. You will be asked for your insurance card and driver's license at the registration desk for identification purposes.

<u>District Dental Contracted Insurance Coverage</u>
If you have coverage through an insurance company that has a contract with the doctor you are seeing, we require a copy of your insurance card and payment of your deductible and/or co-insurance at the time of service. You will also be required to fill out a credit card authorization form.

<u>Non District Dental Contracted Insurance Coverage</u>
If you have coverage through an insurance company that does not have contract with the doctor you are seeing, we require a copy of your insurance card, and payment of your deductible and/or co-insurance at the time of service. We will file the claim as a service to you. You will also be required to fill out a credit card authorization form.

I have read all the information above and agree that, regardless of my insurance status, I am responsible for my account balance for any professional services rendered. Disclosed, non-covered services are my responsibility.

In the event my insurance company is billed, I irrevocably assign and transfer benefits to District Dental. A photocopy of this agreement shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my claim to any insurance company, adjuster, or attorney involved in this claim.

Signature of responsible party_____Date_____

I authorize the release of any medical/dental information necessary to process my claims.

Signature of patient (or guardian)_____Date_____