

SUNCOAST DENTAL CENTER FINANCIAL POLICY

THIS IS OUR POLICY REGARDING PAYMENT FOR TREATMENT. PLEASE TAKE TIME TO READ IT SO THERE WILL BE NO MISUNDERSTANDINGS.

PAYMENT IS EXPECTED AT THE TIME OF TREATMENT.
WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AND CARE CREDIT.*

*(FOR MORE INFORMATION ON CARE CREDIT, PLEASE ASK YOUR PATIENT CARE COORDINATOR OR FRONT DESK.)

WE CAN NOT ACCEPT INSURANCE AS A METHOD OF FULL PAYMENT.

FOR PROCEDURES THAT REQUIRE 2 OR MORE VISITS, ONLY 50% WILL BE REQUIRED AT THE START OF THE PROCEDURE AND THE BALANCE WILL BE DUE AT THE FINAL VISIT.

INSURANCE:

AS STATED ABOVE, WE CANNOT ACCEPT INSURANCE AS A METHOD OF FULL PAYMENT. PAYMENT IS EXPECTED AT THE TIME OF TREATMENT.

INSURANCE IS A CONTRACT BETWEEN THE EMPLOYEE AND THE INSURANCE COMPANY. YOU ARE REQUIRED TO PAY THE FULL AMOUNT CHARGED, REGARDLESS OF WHAT THE INSURANCE COMPANY DEEMS REASONABLE AND CUSTOMARY.

OUR OFFICE IS NOT CONTRACTED OR AFFILIATED WITH ANY INSURANCE COMPANY. IF YOUR INSURANCE COMPANY ALLOWS YOU TO GO TO AN OUT OF NETWORK PROVIDER, WE WILL BE HAPPY TO SUBMIT YOUR CLAIMS FOR YOU.
DUE TO THE COSTS INVOLVED IN PROCESSING AN INSURANCE CLAIM, OUR OFFICE DOES CHARGE A \$2.00 CLAIM FILING FEE.

WE HAVE NO WAY OF ASSURING YOUR INSURANCE PAYMENTS WILL BE MADE FOR ANY SERVICES WE MAY PROVIDE. IF INSURANCE PAYMENT IS NOT MADE, YOU ARE STILL PERSONALLY LIABLE FOR THE PAYMENT OF ANY TREATMENT PROVIDED.

HOWEVER, WE WILL BE HAPPY TO SUBMIT A PREDETERMINATION OF BENEFITS FOR PROPOSED TREATMENT UPON YOUR REQUEST. THIS IS WHEN THE INSURANCE COMPANY PROVIDES US WITH A WRITTEN STATEMENT INDICATING THE AMOUNT THEY WILL COVER, AND WE CAN THEN SCHEDULE TREATMENT. AT THIS POINT, YOU WOULD ONLY BE REQUIRED TO PAY ONLY YOUR CO-PAY AT THE TIME OF TREATMENT.

I UNDERSTAND THAT ANY ACCOUNT BALANCE (INCLUDING THOSE PENDING INSURANCE PAYMENTS) WILL BE SUBJECT TO A SERVICE CHARGE OF 1 1/2 % PER MONTH (ANNUAL PERCENTAGE RATE OF 18%, WITH A MINIMUM SERVICE CHARGE OF \$2.00 ON ANY AMOUNT NOT PAID WITHIN 60 DAYS OF SERVICE. IF YOUR ACCOUNT BALANCE GOES INTO DEFAULT AND ENTERS COLLECTIONS STATUS YOU WILL BE CHARGED AN ADDITIONAL FEE OF 35% OF THE ORIGINAL AMOUNT OWED TO US.

WE DO NOT ACCEPT POSTDATED CHECKS NOR DO WE HOLD CHECKS FOR LATER PAYMENT.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

RESPONSIBLE PARTY NAME
(PLEASE PRINT)

RESPONSIBLE PARTY
(SIGNATURE)

DATE: _____