Financial Policy

TIM M. VERWEST, DMD

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Patient Name: ______________________________ **Account #:** ______________________

Thank you for choosing us as your child's dental office. We are committed to providing your child with optimum dental care. Please understand that payment of your bill is considered part of your child's dental treatment. The following is a statement of our financial policy which we require you to read and sign prior to any dental treatment.

Payment is expected at time of service:
We accept cash, checks and Visa. Mastercard, American Express and Discover credit cards and Visa/Mastercard backed Debit cards.

Minor patients of divorced parents:
A divorce decree is a legal agreement binding only upon the two parties who made the agreement. Regardless of whom the judge deemed financially responsible for dental bills. **THE PARENT WHO BRINGS THE CHILD To THE OFFICE FOR DENTAL TREATMENT IS RESPONSIBLE FOR PAYMENT AT THE TIME OF SERVICE.** The parents can settle the financial responsibilities between themselves. Do not ask us to do this for you.

DENTAL INSURANCE:

We will accept your insurance as **partial payment** for your child's dental treatment. We are not contracted with all Dental Plans, therefore there will likely be a difference between our fees and those of the insurance company-you are responsible to pay this difference, along with all other co-insurance amounts and services.

We do not file claims to HMO or DMO plans that we are not contracted with. We do not file insurance claims for Emergency visits. Consults or Office Visits not associated with periodic cleanings or treatment. You will be responsible to pay at the time of service and we will provide you with a form to submit to your insurance for reimbursement.

To determine exactly what benefits you qualify for under your plan, it may be necessary to submit to your insurance a "predetermination of benefits". If you wish to begin treatment before your insurance company declines your exact benefits you will be required to pay 50% of the fee for your child's dental treatment. Once we receive notice of reimbursement from the insurance company we will adjust your account accordingly.

I understand that it is a courtesy of Dr. Verwest's to file my insurance and I agree to pay any and all balances not paid by my insurance after 60 days from time of service. It is my responsibility to get reimbursement from my insurance company.

Thank you for understanding our financial policy.

I have read the above financial policy. I understand and agree to this financial policy.

Signed: ____ Date: ____