Roseville Smiles Family Dentistry
FINANCIAL GUIDELINES

Our objective is to provide for you the best quality dental care available. This service is based on a friendly, mutual, businesslike understanding between doctor and patient.

Misconceptions may be minimized if our financial guidelines are understood by you at the beginning of treatment.

OUR FINANCIAL GUIDELINES ARE AS FOLLOWS:

Please initial and sign

CASH

This is a fee-for-service dental practice. Payment in full is expected upon completion of each day's treatment. Cash is defined as currency, personal checks, money orders, Visa, Master Card & American Express credit cards. We also have available to you, a third party financial company with Care Credit that you can apply for at any time. There is also a 10% allowance for all cash paying patients.

____ I acknowledge that I am responsible for the complete cost of treatment and enter into this financial agreement willingly. I agree to pay all of the applicable portion of the treatment fees on the day treatment is provided.

INSURANCE

Although this dental practice accepts assignments of payments from more than 300 providers, there is no direct contract with any carrier except with Delta Dental Premier, Delta Dental Preferred, Aetna, Cigna, Guardian, Humana, Premier Access and MetLife. The contract and payment for services exist between the patient and this dental office.

This office is not responsible for knowing patient maximums or how much your insurance will cover. Some insurance companies will ONLY reveal this information to the policy holder. The policy holder is responsible for the entire cost of services rendered regardless of expected or estimated insurance coverage after 45 days, regardless of my carrier's time to pay. When there is a co-payment or a percentage due, it is to be paid at the time the services are rendered at Check-In.

Insurance information, such as identification cards, policy numbers, deductibles, co-payments, maximums, policy manuals and guidelines must be supplied by the patient BEFORE treatment is rendered.

Insurance companies usually pay only a portion of the total fee for service according to a specific plan arranged by the patient or the patient's employer. This office has no prior knowledge of, nor control over, the constantly fluctuating **"USUAL, CUSTOMARY OR REASONABLE" RATES ESTABLISHED BY ANY PARTICLAR CARRER .**

As a courtesy, this dental practice will call your insurance company to verify your eligibility and will input all insurance information given to us prior to your appointment.

_____ I acknowledge that I am responsible for the cost of treatment after 45 days and any portion that the insurance company does not pay and enter into this financial agreement willingly. I acknowledge that the dental office has provided me with only ESTIMATES for treatment that need to be done.

_____ Any treatment not paid in full within 45 days will then be contracted out automatically to TSI (Transworld Systems Inc.), a collection service. In addition, this office will exert a monthly 1.5% interest rate on the unpaid balance.

_____ I also acknowledge that, under either plan, there will be a $35 handling fee for any returned checks or overdrawn credit cards.

RUNNING LATE AND NO SHOWS

____ I realize that any failure to keep appointments will result in a $50 per hour charge and possibly discontinuation of treatment for missed appointments without a 24 hour notice.

I acknowledge that I have read, signed and understood all the financial guidelines listed above.

Signature of Patient or Guardian

Date