SOUTHWIND
Periodontics & Dental Implants, P.A.

FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY, OR YOUR RESPONSIBILITY.

ALL CO-PAYMENTS ARE DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, MASTERCARD, VISA, DISCOVER, AMERICAN EXPRESS AND CARE CREDIT.

(1.) **IF INSURANCE IS INVOLVED, CO-PAYMENT AND ANY DEDUCTIBLE IS TO BE PAID AT THE TIME SERVICES ARE RENDERED**.
(2.) PAYMENT PLANS MAY BE ARRANGED IN ADVANCE BASED UPON ESTIMATED FEES, SUBJECT TO CREDIT APPROVAL.
(3.) ANY ACCOUNT HOLDER FAILING TO MAKE AGREED UPON PAYMENTS THROUGH TWO STATEMENT CYCLES WILL BE ASSESSED $5.00 FOR EVERY STATEMENT THEREAFTER UNTIL BALANCE IS PAID IN FULL. _____**INITAL**
(4.) FAILURE TO ADHERE TO THE AGREED UPON PAYMENT ARRANGEMENTS WILL REQUIRE FULL PAYMENT OF CURRENT CHARGES AND INTEREST UP TO THE CURRENT RATE GIVEN BY OUR FINANCING COMPANY, AS WELL AS ADVANCE PAYMENT OF ANY FUTURE SERVICES. _____**INITAL**
(5.) THE PARENT OR GUARDIAN WHO ACCOMPANIES A MINOR TO THE APPOINTMENT IS FINANCIALLY RESPONSIBLE FOR THE ACCOUNT.
(6.) WE REQUIRE 48 HOURS NOTICE FOR ANY CHANGE OF APPOINTMENT. FAILURE TO COMPLY MAY RESULT IN A FEE TO REAPPOINT.
(7.) HAVE YOU FILED BANKRUPTCY IN THE PAST 10 YEARS OR ARE YOU IN THE BANKRUPTCY PROCESS AT THIS TIME. **YES / NO _____INITAL**

WE FILE INSURANCE AS A COURTESY TO OUR PATIENTS IF CURRENT INFORMATION IS PROVIDED TO US. INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. YOUR BENEFITS DEPEND ON WHAT YOU OR YOUR EMPLOYER NEGOTIATED WITH THE INSURANCE CARRIER. IT IS IMPOSSIBLE FOR US TO HAVE COMPLETE KNOWLEDGE ABOUT THE NUMEROUS DENTAL AND MEDICAL INSURANCE COMPANIES CONTRACTS WITH EMPLOYERS OR YOUR STATUS WITH YOUR PARTICULAR COMPANY. PLEASE NOTE THAT MANY INSURANCE COMPANIES DO NOT PROVIDE THEIR ALLOWED FEES UNTIL AFTER TREATMENT IS COMPLETED OR A WRITTEN PRE AUTHORIZATION IS RECEIVED FROM YOUR INSURANCE COMPANY. THIS CAN SOMETIMES MAKE IT DIFFICULT TO ACCURATELY ESTIMATE YOUR INSURANCE CO-PAYMENT BEFORE TREATMENT IS RENDERED.

UPON RECEIPT OF AN INSURANCE PAYMENT, ANY REMAINING BALANCE IS BILLED TO YOU. A REFUND IS ISSUED WHEN YOU HAVE A CREDIT BALANCE RESULTING FROM A PATIENT OVERPAYMENT.

WE WILL NOT BECOME INVOLVED IN DISPUTES BETWEEN YOU AND YOUR INSURANCE REGARDING DEDUCTIBLES, CO-PAYMENTS, COVERED CHARGES, SECONDARY INSURANCE, OR OTHER MATTERS REGARDING REIMBURSEMENT. IF ACTION BECOMES REQUIRED TO COLLECT A DEBT, YOU WILL BE RESPONSIBLE FOR ANY AND ALL COURT COSTS INCURRED IN THE PROCESS.

I UNDERSTAND I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT REGARDLESS OF WHAT MY INSURANCE CARRIER MAY OR MAY NOT PAY. THIS SIGNATURE WILL ALSO SERVE AS SIGNATURE ON FILE FOR ASSIGNMENT OF INSURANCE BENEFITS. I AUTHORIZE RELEASE OF INFORMATION RELATING TO INSURANCE CLAIMS.

*** IF THE PATIENT IS OVER 18 AND ON A PARENT'S INSURANCE POLICY, THE PARENT MUST SIGN THE FINANCIAL POLICY.**

PATIENT NAME _____

INSURANCE COMPANY NAME _____

POLICY HOLDER NAME (IF DIFFERENT) _____

POLICY HOLDER DATE OF BIRTH _____

PATIENT /GUARANTOR SIGNATURE_____ **DATE**_____