HICKS DENTAL FINANCIAL POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

- **Payment** is expected at time of services rendered. Prompt payment allows us to control cost. We do not offer "in house" financial arrangements. If financial arrangements need to be made, we will assist you with processing a credit application to be submitted to an outside finance company.

- **Insurance** is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company at the time of service as a courtesy to you. It is YOUR responsibility to remit payment for charges not covered by your insurance and assure your carrier remits payment. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You will be responsible for any balance not paid by your insurance company within 30 days of service date.** You will receive a statement by mail and payment is expected by due date indicated on your statement.

- **Divorce**- In case of divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

- **Past due accounts** – If your account becomes past due, we will take the necessary steps to collect this debt**.** A **$25.00 re-billing fee** will be imposed every month on each account that is over 30 days past due and every month thereafter until the balance is paid in full. All patients refusing to remit payment after 61 days of notice will force us to suspend all treatment until the balance is paid in full. We also reserve the right to pursue collections of money owed which may include but is not limited to: outside collection agencies, credit bureau reporting, and legal action. You will be responsible for any fees incurred with collection of your debt.

- **Returned checks**- There is a fee (currently $25) for any checks returned by the bank.

- **Effective Date**- Once you have signed this agreement, you agree to all of the terms and conditions contained herein and agreement will be in force and effect.

Our office firmly believes that a good doctor/patient relationship is based upon understanding and open communications. Our staff is instructed to make every effort to clarify any misunderstanding you have concerning your balance.

I have read and understand the financial policy of Hicks Dental. Any questions I have concerning this policy have been explained by the office staff.

Patient/ Guardian Signature: ______________________________

______________________________ Date ______________________________
Patient Printed Name