

# Benjamin DeShetler, D.D.S.

## Policy and Financial Agreement

Dr. Benjamin DeShetler and staff are pleased to welcome you to our practice. We look forward to providing you and your family with quality care rendered with the "latest and greatest" dentistry has to offer.

Payment is expected upon rendering services. All co-pays, deductibles, etc must be made on the date of service.

We do not bill for services already rendered or have payment arrangement options. We offer Care Credit, a "Dental Charge Card" that allows small monthly payments with extended plans for up to 18 months, no interest.

We gladly accept **Cash, Checks, All Major Credit Cards-Amex, MasterCard, Visa, Discover and CareCredit**. There is a return check fee of **\$25.00** for checks not honored by the bank for any reason.

## Broken Appointment

**We require a 24 hour notice for all broken appointments otherwise there is a \$25.00 fee due at the time of your next appointment.**

## Important Insurance Instruction

We will file your insurance claim(s) as a courtesy to you and your family. Professional Services are rendered and charged to you, not the insurance company. After **60 days**, the account balance is your responsibility.

We do not determine the amount of coverage you will receive: your insurance carrier determines this. Any questions regarding coverage, deductibles, and limitations should be directed to your current carrier.

At time of service, we will contact your insurance carrier and get an "**estimate of payment**" for services rendered based on your coverage percentage rate for various dental procedures. The "**estimated**" portion your insurance does not cover is requested in full at time of service. After your insurance carrier makes payment, you will receive a statement of your account and bill. If there is a difference in the procedure charge and allowed amount by carrier (THE ESTIMATE YOU RECEIVED and REVIEWED).

All account balances must be paid within **15 days**, after receipt of statement. Please be advised that if payment is not made on time, all outstanding amounts shall be deemed to be due immediately and payable without further notice. Failure to pay account may result in INTEREST, COLLECTIONS, AND /OR ATTORNEY FEES being added to the outstanding balance. These charges will be the patient or parent/ guardian's responsibility.

**I have read and reviewed the outlined statements above:**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_