Dental Doctors of Florida
Financial Policy

Dental Doctors of Florida will inform you of all costs before services are administered. Charges are payable at the time of treatment. Our philosophy is to be informative, honest, and forthright. This Financial Agreement is to let you know ahead of time what our expectations are regarding financial arrangements.

We accept all major credit cards, personal checks, and offer financing options through Care Credit and Lending Club. If special arrangements are necessary please speak to our office manager prior to receiving services.

INSURANCE

We will submit primary insurance claims for you and will fully attempt to help you receive full insurance benefits. However, please remember you are personally responsible for your account.

We are a preferred provider for the following insurance companies:

CIGNA PPO
DELTA DENTAL PPO
DELTA DENTAL PREMIER
FLORIDA COMBINED LIFE PPO
HUMANA PPO

- You must provide us with an insurance card and all the information necessary to verify your coverage and file your claim.
- Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company.
- Although we may estimate your insurance benefits, based on information given by your insurance company, we are not responsible for their accuracy. Knowledge of benefits as well as benefits amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance company are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Fees for non-covered services, along with deductibles and co-payments are due at the time of treatment.

After dental insurance has paid its portion, you are responsible for the remaining balance. Payment is expected within 25 days of the statement date, to avoid finance charges.

Patients without Insurance Coverage: We will provide a written estimate of fees. Payment is expected at each visit.

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Minor Patients: The legal parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the parent accompanying the child is responsible for payment, without any exception. This office will not attempt to collect payment from a parent that is not present in the office at the visit.

Returned Checks: A $50 charge applies when a check is returned by the bank.

Finance Charges and Collections Fees: Finance charges may be applied to balances not paid within 25 days of the monthly billing date. A late charge of 1.5% on the balance then unpaid and owed will be assessed each month until paid. It is your responsibility to ensure your insurance company pays promptly so you can avoid finance charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

We understand temporary financial problems may affect timely payment of your balance. In those situations, we encourage you to communicate any such problems immediately so we may assist you in the management of your account.

Overdue Balance: An account with an unpaid balance past 90 days may be sent to the collection agency. At that time, you will be responsible for all cost incurred in the collections of your debt.

Fee for Missed Appointments: To reschedule or cancel an appointment, ***you must notify us 48 hours in advance to avoid a missed appointment fee of $90.*** To be fair to all patients, this fee cannot be waived. We reserve the right to terminate professional treatment of any patient when you are unable to keep a scheduled appointment.

Consent and Authorization: I authorize dental treatment and agree to pay all related professional fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. I have read and understood this document in its entirety, outlining office policies and financial policies of Dental Doctors of Florida.

Patient Name: _____ **Date**: _____
Please Print

Responsible Party Signature: _____