Fairchance Dental Arts
Financial Guidelines

Updated January 2021

Thank you for choosing our office as your dental health care provider. Please understand that payment of your bill is considered part of your treatment.

- As a courtesy to you, we will help you process all of your insurance claims. Please understand that we will provide an insurance ***estimate*** to you, however it is ***not a guarantee that your insurance will pay exactly as estimated***. Your insurance company and your plan benefits ultimately determine the amount paid.

- We ask that you pay the deductible and co-payment if your treatment is **under $250**, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, American Express or Discover **prior to being seated** for your appointment.

- For **treatment estimates over $250**, a financial arrangement will be made in writing. We ask that you pay the agreed upon amount **prior to being seated** for your appointment. Outside financing, such as CareCredit, is available upon approval.

- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will contact your insurance company to make sure payment is expected. *If payment is not received or your claim is denied*, **you will be responsible** for paying the full amount at that time.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

- All charges you incur are your responsibility **regardless of your insurance coverage**. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.

- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance, you will be responsible for any charges incurred.

We are grateful for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial guidelines.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Name, printed: _____

Signature (Patient or Guardian): _____ Date: _____