



## **Financial Policy**

Our office is dedicated to providing superior care and service to you. Your complete understanding of your financial responsibilities is essential to your care and treatment. Please do not hesitate to discuss any questions or concerns you have about the following financial policy with us.

### **Your Insurance**

Dr. Bender is a fee-for-service provider. Payment will be accepted at the time a procedure is completed. Our office will help file all insurance claims for you.

Dr. Bender is an out-of-network provider. However, she is willing to work with each patient's insurance carrier on an individual basis. Our office will allow partial payment for a service when an agreement has been reached regarding estimated dental insurance coverage. A pre-determination of benefit coverage is not an accurate estimation of insurance coverage.

Upon request, Dr. Bender will send your treatment plan along with all supporting documentation and radiographs to your insurance carrier. With this information, your insurance carrier may determine coverage for a particular procedure. The process of obtaining a pre-determination takes approximately one month. The pre-determination is a written **estimate** detailing the expected payment by the insurance carrier for a procedure. Usually the pre-determination information is accurate; however, unprocessed claims or claims processed after a pre-determination has been created will alter insurance coverage.

Dr. Bender will accept payment for the **estimated** patient portion for a procedure and accept the remainder of the payment from the insurance carrier. **ULTIMATELY, YOU ARE RESPONSIBLE FOR PAYMENT AND RECONCILIATION OF YOUR ACCOUNT. DR. BENDER IS NOT RESPONSIBLE FOR INACCURATE ESTIMATES MADE BY AN INSURANCE CARRIER.**

### **Appointment Policy**

Time has been specifically reserved for your dental appointment. To protect the integrity of our schedule and to be fair to those on our waiting list, if you need to change your appointment, kindly give a 48 hour notice. For all treatment appointments we require one week notice. Failure to keep a scheduled appointment without proper notice may result in a minimum charge of \$50.00. We may not be able to see you if you are more than 15 minutes late for an appointment

### **Payment**

We accept cash, check and credit cards (Visa, Master Card, Discover Card, and American Express) for payment. There will be a \$25 charge on all returned checks.

I have read and understand the financial policies of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

\_\_\_\_\_  
(Signature of Patient or Responsible Party)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Printed name of Patient)