OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility. If you do not have insurance, we expect payment in full for all treatment at the time of service, unless other arrangements have been previously made. We accept cash, checks, Visa, MasterCard, Discover, and CareCredit.

If you have insurance, we can assist you in submitting your claim. Your insurance claim will only be completed and submitted if we are provided with all pertinent insurance company information. It is your responsibility to verify that your policy is in effect at the time your services are performed. Otherwise, you are responsible for payment at the time of service.

Insurance is an agreement between you and your insurance company. We will inform you if we are participating with your insurance plan and will handle your claim according to our agreement with the insurance company. We file insurance claims as a courtesy to you, our patient. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, maximum limitations, covered charges, secondary insurances, "usual and customary" charges, etc., other than to supply necessary factual information. If payment is not received from your insurance company by us within a reasonable period of time, the balance of the account becomes your responsibility. I hereby authorize and agree as follows:

* I authorize the use of this information on all my insurance submissions.
* I authorize release of information to all my insurance companies.
* I understand I am responsible for my account.
* I authorize the Fox Dental Team to act as my agent in helping me obtain payment from my insurance company.
* I authorize payment directly to my doctor.
* I permit a copy of this authorization to be used in place of the original.
* I understand benefit information given to me by Dr. Fox or her staff is not a guarantee of payment.
* I understand that full payment of my account must be received within the agreed upon time frame regardless of my insurance. Balances not paid in full within 90 days will result in a collection fee of $25.00 and submission to our collection agency. At that time all future appointments will be cancelled.

PAYMENT PLAN OPTIONS

(1) We offer a Senior Citizen discount of 5% for patients 65 and over ; if payment is made at time of service with cash or check.
(2) CitiHealth and CareCredit – an interest free financing company for either 6 or 12 months – an application must be approved to qualify
(3) Monthly payment arrangements through our office made prior to treatment
(4) Visa, MasterCard, and Discover are accepted

I have read the above Financial Policy and understand that I am financially responsible for all charges, whether or not they are paid by my insurance. I understand that if my account is not paid within 90 days of the agreed upon payment plan, it will be turned over to the Credit Bureau for collection and a $25.00 collection fee will be added.

Patient Name: ______________________________ Signature: ______________________________
(Please Print)

Date: _______________ Relationship to Patient: ______________________________