MAHTOMEDI
FAMILY DENTAL

We believe in optimum communication with our patients; therefore, we ask that you please read the following information and ask any and all questions so that we may help you full understand our financial policies.

FINANCIAL AGREEMENT (FOR ALL PATIENTS):

Upon acceptance of treatment in this office the patient/guardian assumes financial responsibility for payment of fees. **Treatment is to be paid in full when services are rendered unless other arrangements have been discussed and finalized.** This may be in the form of Cash, Check, Visa, Mastercard, Discover or other outside financing. In the event that your account becomes 90 days past due, your account will be handed over to a collection agency or an attorney's office, and you will be responsible for **all incrued costs of collection, including the attorney's fees.**

FOR OUR PATIENTS WITH DENTAL INSURANCE:

Your dental benefits help offset the investment of getting quality dental care performed on you and your family and it is our pleasure to assist you in maximizing your insurance benefits by completing your claims forms. Please be aware that your coverage **depends solely on what you and/or your employer wishes to purchase.** Some plans cover as little at 30% or as much as 100% of dental services, with most falling in the 40% to 80% range. Some plans base the amount of benefit on a fee schedule which is indicated in your dental plan. For example, if your plan states that it will pay 80% of the cost of a specific treatment, it mean 80% of the fee arbitrarily determined by the insurance company and not the actual fee charged by our office. In the event that any treatment rendered at our office is not a covered benefit under the patients dental plan or if our office is not in network with the patients dental plan, the patient/guardian assumes financial responsibility for all fees. **Please understand that any assistance concerning what or how much coverage you have, is for reference only** and should not be your only basis for proceeding with treatment. We do not base our treatment recommendations on what the insurance company will cover but rather what the best treatment is for you. We will assist you in any way that we can . In addition, because of inconsistencies in secondary insurance benefits, we do not consider the secondary benefits when figuring your portion of the charges. We will file secondary claims for you. We collect **estimated** portions calculated by our computer system up front; if there is any remaining balance after receiving this portion it will be due upon receipt of our statement.

Please keep us informed of any changes to your health information as well as your address, phone, email, or insurance information so that we may serve you in the best possible manner.

I have read and understand the above financial policies. I authorize release of any information pertaining to treatment for the purpose of comprehensive filing of insurance claims. I acknowledge full responsibility for the payment of services at the time of service unless other arrangements are made with this office.

X_____ X_____ _____

(Patient or Parent/Guardian signature) **(Patient printed Name)** **Date**