PINES DENTAL ASSOCIATES
FINANCIAL AGREEMENT AND TREATMENT POLICY

WE FEEL THAT BENEFITS WHEN THERE IS A DEFINITE AND CLEAR UNDERSTANDING OF OUR TREATMENT AND FINANCIAL POLICIES PRIOR TO TREATMENT. THEY ARE INTENDED TO ALLOW US TO BE FAIR TO OUR ENTIRE FAMILY OF PATIENTS AND HELP CONTROL ADMINISTRATIVE COST.

APPOINTMENTS

PLEASE BE ON TIME FOR RESERVED APPOINTMENT. WE HAVE EXCLUSIVELY RESERVED THE DOCTOR, STAFF AND FACILITY FOR YOUR DENTAL CARE. WE WOULD APPRECIATE YOUR CONSIDERATION IN GIVING OUR OFFICE A 48 HOURS BUSINESS HOUR NOTICE, SO THAT WE MAY EFFECTIVELY RE UTILZE THE TIME WITH THE DOCTOR OR HYGIENST. IF YOU DO NOT SHOW UP FOR AN APPOINTMENT MADE, WITHOUT SUFFICIENT NOTICE. WE COULD EXERCISE THE RIGHT TO CHARGE YOU A 35.00 FEE PER ½ HOUR BROKEN APPOINTMENT FEE.

FEES

THE FEES FOR QUALITY DENTAL TREATMENT ARE BASES ON THE TREATMENT RENDERED AND THE TIME NEEDED TO COMPLETE TREATMENT. OUR OFFICE BELIEVES THE FEES ARE A FAIR REPRESENTATION OF STANDARD CARE WE PROVIVE AN IN STEP WITH INDUSTRY STANDARDS.

PAYMENT OPTIONS

1. **YOUR INITIAL EXAM PAYMENT IS DUE AT TIME OF SERVICE.**
2. **WE ACCEPT CASH, CHECK, VISA, MC, DISCOVERY, AND AMEX.**
3. **WE OFFER AN UP TO 12 MONTHS INTEREST FREE PAYMENT PLAN TO QUALIFIED PATIENT**

INSURANCE VERY IMPORTANT TO READ THIS SECTION CAREFULLY
IF YOU HAVE ANY QUESTIONS OR CONCERNS PLEASE ASK ONE OF OUR FRONT DESK STAFF MEMBERS

AS A COURTESY TO YOU YOUR CONVENIENCE WE WILL BILL YOUR INSURANCE COMPANY FOR TREATMENT RENDERED, PROVIDED WE HAVE CURRENT AND ACCURATE BENEFITS COVERAGE INFORMATION. PLEASE UNDERSTAND YOUR DENTAL BENEFITS PROGRAM IS A CONTRACT BETWEEN YOU AND YOUR EMPLOYER AND YOUR INSURANCE COMPANY. WE DO NOT HAVE A CONTRACT WITH YOUR INSURANCE COMPANY THEREFORE WE HAVE TO HOLD YOU RESPONSIBLE FOR ANY BALANCE ON ACCOUNT. WE WILL EXPECT YOU TO PAY YOUR DEDUCTIBLE AND OUT OF POCKET PORTIONS AT THE TIME SERVICES ARE RENDERED IN THE EVENT YOUR INSURANCE CARRIER DOES NOT MAKE A PAYMENT WITHIN 45 DAYS YOU WILL NOTIFIED. IF A PAYMENT IS NOT RECEIVED WITHIN 60 DAYS WE WILL BILL YOU FOR ANY OUSTANDING BALANCE. IN THIS INSTANCE WE WILL ASSIST YOU IN GAINING REIMBURSEMENT FROM THE INSURANCE COMPANY.

DISCOUNTS

FOR COMPREHENSIVE TREATMENT PLAN IN EXCESS OF 700.00 A DISCOUNT IS AVAILABLE IF THE ENTIRE FEE IS PAID AT THE TIME OF SCHEDULING APPOINTMENT. YOU WILL RECEIVE A 5% DISCOUNT AND MUST BE PAID WITH CASH OR CHECK.

RETURNED CHECKS

THERE IS A 35.00 FEE FOR ANY RETURN CHECKS

REQUEST FOR XRAYS AND RECORD

THERE IS A 25.00 FEE PER PATIENT RECORD AND XRAYS. PLEASE ALLOW 1 WEEK TO RECEIVE OR PICK UP COPIES.

OUR OFFICE WOULD LIKE TO THANK YOU FOR YOUR TIME AND COOPERATION AND TRUST US TO DELIVER COMFORTABLE, SAFE AND QUALITY DENTAL CARE TO YOU AND YOUR FAMILY AND FRIENDS. WE WOULD ALSO APPRECIATE YOUR UNDERSTANDING IN NECESSARY OF THE AFOREMENTIONED GUIDELINES AND PROCEDURES.

I HAVE READ AND UNDERSTAND AND WILL ABIDE BY THE INFORMATION CONCERNING THESE OFFICE POLICIES.

_____ _____

RESONABLE PARTY SIGNATURE **PRINT FIRST AND LAST NAME**

_____ _____

RELATIONSHIP TO PATIENT