MY Dentists Financial Policies and Release of Information

Thank you for choosing MY Dentists for your dental health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health.

Please understand that processing your claim and payment of your bill is considered part of your treatment. So that we may better serve you, we ask you to please read, sign and return this form to us prior to your treatment. If you have any questions or concerns regarding our payment policies, please do not hesitate to discuss them with us. All patients should provide accurate and complete insurance information prior to being seen by the doctor. We will ask that you present your insurance card upon check-in at each visit so that we can verify coverage and the estimated deductible/percentage for services.

- Deductible/estimated portion for office services are required at the time of service unless prior arrangements have been made.
- We accept Cash, Check, Debit Cards, Visa, MasterCard, Discover, AMEX, Care Credit and Chase Financial.
- We will file your insurance claims for services as a courtesy. Once applicable insurance has paid, any remaining balance will be the responsibility of the patient due upon receipt of statement.
- You will receive a statement each month from us as a reminder to follow-up with your insurance company to ensure your claim has been processed. The balance on your account is due in full 60 days after the date of service regardless of insurance payment.
- Any account 60 days or older will assess finance charges at a rate of 1-1.5% per month, 18% per year.
- If your insurance company is one that reimburses you directly for services ex: Delta Dental, payment for services rendered will be collected in full at the time of service.
- Please be aware that some insurance plans have exclusions for services and/or waiting periods. Although we make every effort to notify you of such policies, we cannot be familiar with every insurance plan. You are responsible for any non-covered or denied services.
- We recommend that all patients contact their insurance company to better understand their benefits and how claims will be processed.
- If the patient is a minor (18 years and younger), the parent or guardian is responsible for payment of the account, in accordance with the policies outlined herein.

Missed Appointments: Please help us serve you and our other patients by keeping all scheduled appointments**.** If you are unable to keep an appointment please notify us (even after hours) at least 24 hours in advance 704.375.8577. Failure to notify us with in less than 24 hours of your appointment may result in a minimum broken appointment charge of $42.00.

R**eturned Checks**: For checks returned to us, as unpaid by your bank, we will charge you a $35.00 fee.

Past Due Accounts: Over due accounts will be referred to a collection agency if more than 90 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process.

I certify that I have read and understand the "Financial Policies" and agree to all terms and conditions as stated above. I certify that the information that I have provided is correct to the best of my knowledge. I understand that it is my sole responsibility to verify insurance coverage and I also understand that it is my responsibility to inform MY Dentists of any changes associated with my insurance status. I agree to make an in-full, prompt payment to MY Dentists when billed for any and all charges not covered or paid by insurance. I hereby assign and direct to pay any and all benefits for dental services under this claim to MY Dentists.

I authorize the release of any dental information to my primary care or referring physician, to consultants if needed and as necessary to process my insurance claims and prescriptions. I authorize the use of this signature on all my insurance claims.

MY Dentists has my authorization to charge my credit card for any current or past due personal balance upon receiving my verbal or written permission.

Patient/Guardian Signature: _____ Date: _____