FINANCIAL POLICY

Effective August 1st, 2024

To reduce confusion and misunderstanding between our patients and the Practice we have adopted the following financial policy. If you have any questions about the policy, discuss them with our Practice Manager. We provide the best possible care and service to you and regard your complete understanding of your fiscal responsibility as an essential element of your care and treatment.

It is important that you keep all your demographic and insurance information current. Please let the front office staff know if any changes occur.

PAYMENT IS DUE AT THE TIME OF SERVICE

- **PAYMENTS ACCEPTED** – For your convenience we accept the following methods of payment: Debit Cards, Visa, MasterCard, Discover, American Express, Care Credit, Cash, Money Order, and Checks (*for established patients with good account standing over 6 months*). Unless you have dental insurance **for patients with dental insurance a payment of 80% of fees will be due at the time of service.**
  - Since we are not in network with any dental insurance companies, we are no longer able to provide an estimate of insurance payments.

- **PRIMARY INSURANCE** –. We are **NOT** in network with any insurance; however, we can help you file with most insurance plans.
- Dr Welch and Staff put your dental needs above all and will not let dental insurance dictate your care.
- We will attempt to verify your insurance coverage; however, we will require payment of **80%** of the service cost at the time of service. We will submit your claim to your insurance as a courtesy. If we are unable to verify your coverage you will be responsible for payment in full at the time of service. Patients are responsible for understanding and abiding by the terms of their own dental plans.

Payment is due upon receipt of a statement from our billing office.

OTHER FINANCIAL POLICIES –

- **Collections – In the event that this office is unable to collect payment, and you have not contacted us to make payment arrangements promptly within 120 days, your account will be charged a $500 collections fee, and your account will be turned over to a collection agency.**

I have read and understand the financial policy of this Practice and I agree to be bound by its terms.

Signature of the Patient or Responsible Party **Date**

X_____ X_____

PATIENT IS ULTIMATLEY RESPOSABLE FOR COST OF SERVICES