Who Does Your Teeth?
Dr. Jeffrey Neal & Team

OFFICE POLICIES AND FINANCIAL AGREEMENT

We view our patient relationships with a deep sense of responsibility. A major part of that responsibility is to help our patients understand and plan for their oral health along with providing each patient the highest quality of dental care. We ask that you please read, agree to and sign the agreement before any treatment is rendered.

REGARDING INSURANCE:
For decades dental insurance has been an integral part of oral health planning; however, in the past few years it has become more difficult for the dental practice to work with insurance companies. We are a third party to the contract and the insurance companies are not obligated to share your confidential policy information with us or ***required*** **to send payment to us. If we know your insurance plan will not pay us directly, then you will be responsible for full payment at time of service.** There are constant changes being made by your employer and insurance carriers to your coverage, deductibles and annual maximum. These changes are not always shared with us. Therefore, it is impossible for us to know EXACTLY what your policy covers. We provide the courtesy of submitting the claim on your behalf and supporting you with maximizing your benefits. However, we are unable to carry your expected insurance portion for longer than 60 days. Policy coverage, changes and follow-up on unpaid claims is your responsibility. **We are considered an out of network provider. This status allows us to maintain our high level of service to you, our patient.** _____ (Initial)

PAYMENT OPTIONS:
Your options include Cash, Check, MasterCard, Visa, Discover and American Express. We are pleased to offer you a choice of No Interest or Extended Payment Plans to qualified applicants through CareCredit, our financial partner. If you would like to make extended payments for services provided at our office, please ask us for assistance in filling out an application form. _____ (Initial)

ADDITONAL CHARGES FOR DELINQUENT ACCOUNTS:
A fee of $35.00 **will** be charged on all returned checks OR credit card auto drafts that were denied. After 90 days, accounts not paid in full are charged a $30 Late Fee. When a delinquent account is sent to a third party, **you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collections efforts.**_____(Initial)

Complex Case Reservation Deposit:
We view our patient care with a deep sense of responsibility, because of this we reserve an appointment time that is solely dedicated for your treatment. In cases of treatment that will require at least 2 hours of dedicated time or a minimum dental treatment cost of $1000.00; we require a deposit of $100.00 at time of scheduling. This deposit will be applied to any fees upon the completion of your treatment. Please note, should you fail to follow the cancellation policy, you will forfeit your deposit. _____ (Initial)

I have read, understand, and agree to the above Office Policies and Financial Agreement.

_____ _____ _____
GUARANTOR SIGNATURE **PRINT GUARANTOR NAME** **DATE**