Providence Dental Group
Patient Responsibility Payment Policy

Thank you for choosing our practice. We are committed to providing the best possible care. The following information is provided to avoid any confusion regarding payment for our professional services. Please sign below that you have read and agree to this Policy.

Payment Policy

- We accept cash, check, Visa, Master Card, Discover and American Express
- At the time of your visit, you are responsible for paying your co-pay and any deductible not met. Your insurance company requires us to collect your co-pays and deductibles. It is your responsibility to know what is covered by your insurance.
- 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 above. If parents are divorced, the adult who brings the child to the appointment is responsible for applicable fees.
- If your account is more than 90 days overdue, it will be considered delinquent. Your account will be turned over to collections and a finance charge will be added.
- A $30 charge will be applied to your account the first appointment you miss without 24 hour notice.

Insurance

As a courtesy, we will file your insurance. However, it is your responsibility to know your benefits, to notify this office of any changes to your insurance coverage, and to pay any amount that is determined to be your responsibility. Your insurance policy is a contract between you and your insurance company. We are not a party to this contract. If your insurer has not paid within 45 days from filing, you will be billed for the entire amount even if the claim is being appealed. If an appeal is necessary, we will appeal your claim one time only. It is your responsibility to contact your insurance company if payment has not been made, although we will help provide any information required from our office.

Acknowledgement and Authorization

I have read, understand, and agree to the above Payment Policy. I understand that any charges not covered by my insurance company are my responsibility.

_____ _____
Signature Date

_____
Printed Name