FINANCIAL POLICY

We want to extend our thanks for choosing our dental office. We care about your dental health and will do our part to provide excellent dental care for you and your family. To avoid any confusion after your visit, please review our financial policies below, initial each provision and sign and date the bottom of this form.

______ PAYMENT IS DUE AT THE TIME OF SERVICE: We will expect payment from all patients at the time of service. If you have insurance, we will estimate what your insurance will pay and collect the balance from you at the time of service. Please understand that the figures that we calculate are only an estimate, and is not a guarantee of insurance payment.

______ INSURANCE: We do accept assignment of insurance benefits, and we are happy to file the necessary forms to help you receive the benefits of your coverage. However, if your insurance carrier does not pay for any dental services that we provide, then you are responsible for those charges. Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

______ We will follow-up on your insurance for 90 days from the date of service. If there has been no payment of the claim at that time, we will then ask you to pay for the service and seek reimbursement from your insurance carrier. We will provide you with the appropriate insurance claim form to do this.

______ USUAL AND CUSTOMARY RATES: Our practice is committed to providing excellent dental care for our patients and we charge what is usual and customary for our area and the level of care which we provide. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

______ CANCELLATION OR MISSED APPOINTMENTS: There will be a $50 fee charged on any appointment canceled without 24 hours notice. There will be a $50 fee for missed appointments without any notice. We do have an answering machine that is available after business hours for your convenience.

I have read and understand this Financial Policy. I hereby agree to this Financial Policy and authorize Dr. James S. Swanson to release any information necessary to bill and collect payments for dental services provided.

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PRINT NAME	SIGNATURE	DATE

Please turn page over to complete HIPAA privacy form.