VER: 2/2014

FINANCIAL POLICY AND INSURANCE AGREEMENT

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and understanding of our payment policy. **Payment for services is due at the time services are rendered**. We accept cash, checks, debit, Visa, MasterCard, Discover, American Express, Care Credit and Wells Fargo.

Returned checks are subject to a $30.00 fee. Balances older than 30 days may be subject to additional collection fees and interest charges of 1 ½ percent per month. A $50.00 charge will be assessed for broken appointments and appointments cancelled without 24-business hours advance notice.

If you have dental benefits, we will assist you in obtaining your maximum allowable per year. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to the contract.
2. Our fees are generally considered to fall within the acceptable range (UCR) by most companies and therefore are covered up to the maximum allowance determined by each carrier. UCR is defined as "usual, customary and reasonable fees for this region." This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees which bears no relationship to the current standard and cost of care in this area.
3. Some insurance companies arbitrarily select not to cover certain services in their contracts.

I hereby ask and authorize payment from my insurance company directly to **Bayview Dental Associates**. It is considered a method of reimbursement for fees paid to the doctor and is not a substitute for full payment. I also understand that I am responsible for all costs of dental treatment, including, but not limited to, any fees my insurance company does not cover. I also authorize the release of any information relating to my claim. In the event of a problem, I hereby ask and authorize **Bayview Dental Associates** to speak to the Insurance Commissioner on my behalf.

I also authorize that insurance overpayment will remain in my account as a credit balance toward future services and are not transferable. Reimbursement requests for overpayment may be made **in writing**. Refunds will be made in the same manner as the initial transaction and may take up to 4 weeks to process.

I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

Should it be necessary to collect my account through an attorney or collection agency, I hereby agree to pay all costs of collection, including attorney's fees, collection costs. And court costs.

I have read and fully understand the above information and agree to its conditions.

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Patient Signature **Date**