Bay Hill Dental, Ltd.

FINANCIAL POLICY

We will assist you in every way possible to maximize your dental insurance benefits, including retrieving estimated benefits, filling out and filing the claim forms at no charge. **Nevertheless, your policy is an agreement between you and your insurance company, not between your insurance company and our office. We can make no guarantee of any coverage, but we'll do our best to see that you receive your maximum benefits.**

PLEASE INITIAL BELOW, ACKNOWLEDGING THAT YOU HAVE READ & AGREE TO COMPLY:

_____ **I understand that I am responsible for my total obligation, should my dental benefits result in less coverage than anticipated, regardless of the reason of nonpayment.** *Not all of the services we provide are covered benefits. Benefits differ from one company's benefits to another. Fees for non-covered services, along with deductibles & co-payments are due at the time of treatment.*

_____ **I understand that Bay Hill Dental, Ltd. will only file my primary dental insurance claims.** *You may file the secondary insurance claims. (We are more than happy to provide you with any additional information you may need to process these claims.)*

_____ **I am responsible for keeping track of and being familiar with my dental insurance benefits (including procedure frequencies, waiting periods and yearly maximums/deductibles).** *We try our best to keep track of and monitor your benefits, but it is essentially the policyholder's responsibility. Please ask the front desk at any time for any type of procedure codes/information on upcoming appointments, so that you may call your insurance to find out limitation and frequency details.*

_____ **I authorize payment for services rendered to be paid directly to Bay Hill Dental, Ltd.. If information is supplied at the time of visit, then insurance claims will be filed with the contracted carriers.**

_____ **I understand that payment is due AT THE TIME THE SERVICES ARE RENDERED. In the case of dental insurance, my estimated patient portion would be due at the time of service. Once my dental insurance has issued payment for their portion, any remaining balance would become my full responsibility.** *Please note there will be a finance charge of 2% per month (of the full balance) applied on any remaining balance after 60 days.*

_____ **Upon the circumstance that my account is sent to a collection agency,** *(this action would incur after 90 days of billing statements and a final notice)* **my total account balance would be increased by 30% for collection costs. This 30% increase would include attorney fees, court costs and all other related costs.**

_____ **I am aware that when I make a payment, Bay Hill Dental, Ltd. accepts cash, personal checks, VISA, MasterCard, Discover and Care Credit.**

_____ **I understand that any checks returned to our office due to insufficient funds will be charged a $30.00 reprocessing fee.** *Once a check is returned, Bay Hill Dental, Ltd. will no longer be able to accept a payment by check from you or a family member.*

_____ **In the case of minors: the parent or guardian accompanying the minor to the appointment is responsible for full payment. In the case of divorce/separation, the parent/guardian that brought the minor to the appointment is responsible for payment, no exceptions.**

_____ **Copies of my professional records, such as x-rays, will be charged a $10 duplication fee.**

Responsible party signature _____ Date_____