JACKSON SQUARE
DENTISTRY

We are committed to providing our patients with the best dental care possible, which includes an open dialogue of our fees and financial policies. This agreement provides a written statement of our policies and procedures; any questions can be discussed with a member of our front-desk staff.

1. **Payments.** It is customary to pay in full for all services rendered on the same date of service. If you have verified dental insurance, your estimated co-payment applies. For your convenience, we accept: Flex Spending Account (FSA, HSA) cards; cash, checks, Visa, MasterCard, American Express, Discover and bank-issued debit cards.
2. **Dental Insurance.** Your insurance policy is a contract between you and your insurance company. As dental care providers, we want to emphasize that our relationship is with you, not your benefit provider. If your plan utilizes a reduced/limited fee schedule and/or **your insurance does not cover all or part of the treatment provided, you are responsible for the difference on your account.** Pre-authorizations to your insurance company are happily provided upon request. We will work with you to achieve the maximum benefits for your coverage without compromising your dental health. Claim forms to your benefit provider will be prepared and mailed as courtesy to you.
3. **Treatment Plan Estimate.** Once we have diagnosed your dental health, we will present you with a written treatment plan that provides a detailed estimate of our total services, alongside the estimated benefit portion and your approximate co-pay. Please note that dental benefits are subject to various "exclusions and limitations" as determined by your benefit provider. All co-payments are due at the time of service. The estimate of fees is guaranteed for sixty (60) days, after which fees are subject to change.
4. **Late Fees.** Should your account exceed sixty (60) days, one and one-half percent (1.5%) interest per month (18% per year) will be charged on the outstanding balance. In the event your account exceeds ninety (90) days after all insurance claims have been paid, you will be sent to a collection agency and/or small claims court. Any costs incurred by our practice that are associated with the default of payment will be your responsibility. By signing below you agree to be responsible for all attorneys' fees and other court costs associated with enforcing this agreement.
5. **Returned Checks.** Checks returned for any reason are subject to a "returned check charge" of $35.00. We will require cash or money order as payment for the check + $35 fee.
6. **Cancelled Appointments.** Every time you schedule an appointment, staff, operatory space, materials and the doctor's time have been set aside and reserved for you. If you experience a **true emergency** and cannot keep your appointment, kindly give us as much notice as possible. **Please note that failed appointments or late-notice cancellation/rescheduling with insufficient notice [within two (2) Business Days of the scheduled appointment time] <u>may</u> be subject to a charge of $95.00.**

I have reviewed the above terms and agree to be fully responsible for payment of treatment provided by this office. Further, I authorize this office to file claims to my insurance carrier on my behalf.

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Patient or Parent/Guardian Date

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