Cassity Implants And Periodontics

(Rev 2/15)OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

"Advanced techniques for more comfortable care."

South Ogden	Kaysville
5331 S Adams Ave. Suite A	347 N. 300 W. Suite 201
801-475-5577	**801-444-2696**

Thank you for choosing us as your dental provider. The following is an explanation of our financial policy and agreement; you must read and sign this agreement prior to any current and future dental/medical evaluation in this office.

- **Each patient is responsible for their own bill.**
- **Co-payment:** Payment of all insurance co-payments and deductibles is required at the time of service.
- **Cancellation fee:** Failure to cancel appointments without 7 days notice will result in the forfeit of your deposit, $100 for periodontal surgery procedures or $200 for implant procedures.
- **Returned payment fee:** We may charge your $25.00 each time your check or other payment in returned to us for any reason.
- **Monthly payments:** Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1.5% each month (18% annual rate) will be charged to the amount not paid after 30 days, with a minimum charge of $3.00 per month. By signing below, you acknowledge receipt of this financial policy and agreement and you agree to pay collections costs and/or reasonable attorney's fees if any delinquent balance is referred to an agency or attorney for collection or suit.
- **Late appointments:** Our office will reschedule appointments that are more than 15 minutes late.
- **Notifying our office of any changes:** It is the responsibility of the patient to inform our office of any changes in insurance information, employment status, home address, and phone numbers.
- **You are responsible for knowing what your insurance covers** and the providers and network(s) covered under your dental insurance plan. Any service provided, but not covered by your insurance company will become your responsibility.
- **If your insurance company has not paid your account in full within 60 days, your account balance must be paid by you without further delay.**
- **Your insurance policy is a contract between you and your insurance company**. We bill your insurance company as a courtesy to you, and will be happy to assist you in filling out your insurance claim. We want you to realize, however, that your insurance is a contract between you and the insurance company. You are ultimately responsible for any unpaid portion of the account. In order to facilitate claims processing, you must provide all insurance policy information and any changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment or your insurance claim.
- **Patients who have no insurance are required to pay 100% of services rendered at each visit.** If this is impossible, you will need to make payment arrangements prior to any dental evaluation or treatment. **We accept cash, checks, and Visa/MasterCard/Discover/American Express.**
- **Collection Fee:** The undersigned further agrees to pay an additional amount representing 50% of the principal balance if the account is referred to a collection agency or attorney for collection. I/we agree to pay all attorneys fees with or without suit, and court costs. This additional amount is in recognition of the costs associated with said collection action processing.
- **I grant my permission to you or your assignee to telephone me at home or at my workplace** to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.
- I hereby authorize payment directly to **Cassity Implants & Periodontics** of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.
- I hereby authorize **D. KIM CASSITY, DMD, MS AND/OR Associates** to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge.
- I authorize **Cassity Implants & Periodontics** to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

Signature