

Dyer Family Dentistry
890 Richard Road
Dyer, IN 46319
(219) 322-1326
www.DyerFamilyDentistry.com

Our Financial Agreement

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Successful financial arrangements are part of successful, predictable treatment results. Successful financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and our patient's financial capabilities. Please read and sign the following:

Payment

Payment in full for your estimated portion is due at the time of service, unless prior arrangements have been made. We offer several payment options for your convenience:

1. We accept Cash, Checks, Visa, MasterCard, Discover and American Express.
2. We offer pre-payment discounts.
3. We offer monthly payment plans through Care Credit, Capital One and Chase Health Advance.

Our Fees

We are committed to providing excellent dental treatment to all of our patients. Our fees reflect our team's level of expertise and the quality of care we deliver.

Insurance

Our office is committed to helping our patients maximize their benefits. Dental insurance is becoming extremely complex. We are always available to answer your questions. Nevertheless, your insurance policy is a contract between you and your insurance company. As a dental provider, we are not party to that agreement. **Your co-pay must be paid at the time of service.** As a service to our patients, if you bring all insurance information, we will bill your insurance company. If you cannot provide us with the necessary insurance information, payment in full is expected and you will need to bill your insurance company for reimbursement. The quality of insurance policies varies greatly, **therefore we can estimate your coverage in good faith, but cannot provide any guaranteed coverage due to the complexities of insurance contracts.**

Missed Appointments: There will be a charge of \$50.00 for a missed appointment with a hygienist, and a charge of \$100.00 for a missed appointment with the Doctor, if there is less than a 48 hour notice given.

Minors

Payment for services of the treatment of minors is the responsibility of the adult accompanying that minor.

Service Charges

The policy of this office is to charge a 1.5% monthly (18% annual percentage rate) or a billing charge, which will be applied to all accounts over 60 days past due. We will charge a \$25 fee for returned checks.

Financial Consent

The patient (account holder) agrees to be fully responsible for total payment of treatment performed in this office. I understand and agree to this Financial Policy and Agreement.

Signature of patient/responsible party

Date

Print name of patient/responsible party

Signature on File

I authorize release of any information relating to this claim or any insurance information. I understand that I am responsible for all dental treatment not covered by my insurance.

Signature of patient/responsible party

Date

I hereby authorize payment directly to Dyer Family Dentistry or the group benefits otherwise payable to me.

Signature of patient/responsible party

Date