Financial Policy for Overhill Dental

All patients please read carefully

- *All patients are personally and financially responsible for dental treatment received.*
- Treatment estimates are honored for a period of 60 days from initial examination.
- A finance charge of **3%** interest per month will be charged to unpaid accounts over **60** days.
- Unless prior financial arrangements have been made, payment is expected as services are rendered.
- Major dental restorations (crowns, partials, dentures, bridges, veneers) are guaranteed for a period of **90 days** from the time of placement.

Dental Insurance Patients

- **PLEASE BE AWARE THAT DENTAL INSURANCE COVERAGE IS *NOT* A GUARANTEE OF PAYMENT BY YOUR INSURANCE COMPANY FOR SERVICES RENDERED. EACH PATIENT WILL BE GIVEN AN *ESTIMATE* ANTICIPATED INSURANCE REIMBURSEMENT AND PATIENT CO-PAYMENT PRIOR TO DENTAL TREATMENT.**
- Our office does not accept insurance payment only as total reimbursement for services. *This is insurance fraud.* Your patient share will be estimated at the time of treatment.
- Patients are responsible for their annual insurance deductible.
- Eligibility of dental benefits will be checked with the insurance company at the first appointment or when insurance coverage changes.
- Insurance benefits can be pre-authorized prior to starting major procedures at patient's request, however it is not a guarantee for payment from the insurance company.
- All insurance benefits must be assigned to the dental office or payment must be made at the time of treatment.
- If your insurance rejects your claim for any reason, you will be financially responsible for the treatment rendered. If the insurance company pays less than estimated, we ask that you make prompt arrangements to pay the balance due on your account.
- For patients with dual insurance, treatment on major work may not fully cover the cost of treatment. If this occurs the patient will be responsible for the remaining unpaid balance.
- ***A $35 insufficient funds fee will be assessed to your account if a check is denied and/or returned from the bank.***
- ***A $75 non-cancellation fee will be assessed to your account without 24 hour notification; one courtesy adjustment will be given for the first cancellation without proper notification.***

If you have any questions regarding this policy, please ask the business coordinator for clarification. We welcome the opportunity to discuss it with you.

By signing below, the patient has read and understood the financial policies as set forth in this form.

Patient Signature_____ Date_____