ROCKSIDE FAMILY DENTAL CARE
Financial Agreement

Payment for Services
Payment is expected **in full** at the time services are rendered, unless previous arrangements have been made.

Insurance:
If you have insurance, it is a contract between you, your employer, and the insurance company. As a **courtesy**, we submit claims to all dental insurance companies, whether we are a participating provider or not. Upon your request, we will perform a complimentary benefits check, but understand that we are merely relaying information from your insurance company, and we will not be responsible for any difference between the information provided by the insurance company and the benefit payout.

Usual & Customary Rates (UCR):
We are committed to providing the best treatment for our patients, and this commitment is reflected in the materials we use, the laboratories we do business with, and our fees. You are responsible for payment of your bill, regardless of your insurance company's arbitrary determination of their UCR.

Secondary Insurers:
Having more than one insurer DOES NOT mean that your services will be paid in full. We will bill your secondary carrier as a courtesy. You are responsible for any balance as soon as your secondary claim is processed.

Any claim not paid within 60 days will be closed and will be due in full by you at that time. Regardless of what your insurance company pays, the balance is ultimately your responsibility. Once your claim is paid or rejected, we will send you a statement, which will be due IN FULL at that time.

Divorce Decrees:
This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of service.

Minor Patients:
The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment.

Interest & Rebilling Fees:
We reserve the right to charge interest in the amount provided by state law. Or, at our option, we may charge a rebilling fee of $10 per statement. Additionally, we reserve the right to assess fees in accordance with collection proceedings.

I have read the Financial Policy. By signing below, I indicate that I understand and agree to abide by this policy.

_____ _____
First and Last Name of Patient (printed) **Printed Name of Parent/Guardian if patient is a minor**

_____ _____
Signature of Patient (or Parent/Guardian if patient is a minor) **Date**