

SERENITY DENTAL SPA

Financial Policies

YOUR SIGNATURE AT THE BOTTOM OF THIS PAGE INDICATES THAT YOU UNDERSTAND AND AGREE TO OUR FINANCIAL POLICIES.

Full payment is due at the time services are rendered.

FOR PATIENTS WITH INSURANCE:

As a courtesy to you, our staff will verify your insurance coverage prior to your appointment and a detailed treatment plan with ESTIMATED fees will be provided to you prior to performing any procedures. It is important to understand that this is an ESTIMATE ONLY. In the event that your insurance does not pay as much as we anticipated or if services rendered are denied by your insurance company, you are responsible for the remaining balance on your account. It is imperative that you inform us of any changes in your insurance coverage **PRIOR TO TREATMENT** so that we can provide you with the most accurate treatment plan.

Although we will be happy to assist you in any way we can, your insurance policy is a contract between you, your employer, and the insurance company, and you are responsible for knowing your benefits. Please be aware that some, or perhaps all, of the services provided may not be covered (or may be considered at an alternate benefit). If there is a problem with your insurance company, we will try to help appeal the decision.

Any claims unpaid within 90 days of the date of service will become the patient's responsibility.

- *Payments may be made via Cash, Discover, American Express, MasterCard or Visa*
- *We do **NOT** accept personal checks.*
- *A charge of **\$50 per hour** may be applied to your account for broken appointments, unless a 48-hour notice is given.*

I understand the above and agree that if full payment is not made within 60 days, I am responsible for the balance on the account for services rendered. If my account goes to a third party for collection, I understand that I will be responsible for any fees involved in the collection process. This includes but is not limited to court costs and attorney fees in addition to the outstanding balance.

Patient Name: _____ **Date:** _____

Signature: _____ **Relationship to the patient:** _____