



Insurance and Financial Policy

Our team is committed to providing outstanding dental care to you, our valued patient. Some patients have dental insurance benefits and some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

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_____ Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.**

_____ Although we maintain a computerized history of payments by insurance companies, fees do change and it is impossible to give you a guaranteed quote at the time of service. Our estimates are just that: **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you a more accurate idea of out of pocket figures you may require.

_____ We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Prewitt Dental Group reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and cannot be part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

_____ Prewitt Dental Group requires payment in full for your portion at the time of service. We accept credit cards, HSA cards, cash and checks. (Checks only for existing patients with established payment history). **We do not accept checks for over \$500.00 for any patient.** Care credit is also available.

_____ A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hour notice to avoid a \$50 cancellation fee.**

_____ In the event of any emergency after regular business hours a **\$55 emergency fee** will be charged for established patients in the addition to the necessary treatment fees. Patients who are not established in the practice will be charged **\$125 after hours emergency fee.**

I agree with the above conditions.

Print Name: _____ Date: _____

Patient/Parent Signature: _____

