

# DURBIN DENTAL

## Financial Policy

Thank you for choosing us as your dental provider. We are committed to your superb dental health and achieving a terrific smile. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require that you read and sign prior to any initial treatment at our office.

Full payment is due at the time of service. We accept cash, check, Visa, Mastercard, and Discover and American Express, Care Credit and Dental Fee Plan.

You will be responsible for collection fees on delinquent accounts. Cancellations without 48 hours notice can result in a charge of 25% of appointment production.

## Regarding Insurance

We will gladly file your claim with your dental insurance company however; your Insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits with your Insurance company we require any balance/copay /deductive to be paid at the time of service. Please be aware that some services may be “non-covered” services according To your insurer and ascertains that they are not responsible necessary for your care.

In such a case you will be responsible for all “non-covered” services. You will be mailed a bill regarding any services not covered by your insurance company.

## Usual And Customary Rates

We are committed to providing the best dental care possible for our patients and we Charge what is usual and customary for our area. Durbin Dental participates with certain insurance companies and the office accepts the contracted amount. Even in the instance, however, the patient is responsible for co-insurance, deductible, co-payments, and non-covered services, at the time services are rendered.

Thank you for understanding. Please let us know if you have any questions or concerns.

**The undersigned understands and agrees that the account balance is due, in full, upon receipt of the statement. If the account is not paid in full within 30 days from the date the statement is received, the undersigned agrees to be liable for all costs of collection, including attorney’s fees and court costs.**

X \_\_\_\_\_ Date \_\_\_\_\_  
Signature of Patient/Responsible Party