PATIENT FINANCIAL LIABILITY FORM

Please understand that full payment of your account is considered part of your treatment and is required for all services rendered. Also, payment for past services rendered and treatment given is required before all future services and treatment may be made. We expect full payment at the time the services are rendered. This office accepts Visa and Mastercard. Checks are accepted with a valid photo ID, but returned checks are subject to a $65 fee. Extended payment plans MAY be offered with prior credit approval, but must be made prior to treatment. All unpaid accounts are sent to collection after payment is not made in a reasonable time period and may adversely affect your credit. You agree to pay all fees incurred in the pursuit of delinquent account balances. Please understand that non-emergency services can be denied for delinquent accounts and collection action may affect your patient status with this practice.

INSURANCE IS ACCEPTED UNDER THE FOLLOWING CONDITIONS:

All patient portions and deductibles are due to Nikole O'Bryan, DMD at the time of services. Patient agrees to pay all deductibles, coinsurance, and services deemed "patient responsibility" as identified by the insurance carrier. Deductibles, coinsurance and patient portions are billed monthly upon receipt of the patient's insurance statement from the carrier regarding the patient claim. YOU, the patient, are responsible to render payment once billed for the remainder due for treatment, should there be a balance after the payments made at time of services and the insurance benefit. Claim payments denied by the insurance carrier for any reason become the responsibility of the patient and you agree not to withhold payment from the Practice in the event of a dispute between you and your carrier.

Although we make every effort to obtain accurate information from the insurance carrier, verification of benefits is not a guarantee that an insurance carrier will pay a claim, or pay the amount estimated. Patients are responsible for checking their benefits prior to treatment. The insurance carrier makes final determination, based upon the plan's level of coverage and associated policies, upon receiving the claim.

Cost of Treatment

Treatment plans are customized for your individual care. To that end, we want you to be aware of your financial investment into your care and do so by providing estimates of your out-of-pocket expenses based upon the insurance benefit information you provide us with. Please understand that any estimate given is JUST an estimation of costs as there are many factors that contribute to the treatment and insurance coverage. Denied claims are the responsibility of the patient. Initials:_____

Missed Appointments

We require a 48-hour notice of appointment cancellation. Appointments missed or cancelled on late-notice may be charged a fee of $100.00 PER HOUR MISSED. Initials:_____

Minors

The parent(s), guardian(s), or Financial Guarantor is responsible for full payment at the time of service and will receive the billing statements. A signed release may be required for unaccompanied minors.
Initials:_____

Past Due Accounts

I/We agree to pay all attorneys fees, court costs, and filing fees, which may be assessed by any collection agency or law firm retained to pursue the matter. Additionally, past due balances shall accrue interest at the rate of twelve (12%) percent per annum. Initials:_____

Accounting Principals

Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding services. Initials:_____

Address Changes

It is our policy to provide invoices for any amounts owed on your account. We send all correspondence to the address information you provide, so please advise us anytime there is a change to your address, telephone number or other contact information. Initials:_____

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a $65.00 fee. Initials:_____

I authorize Nikole O'Bryan, DMD to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to my account with Nikole O'Bryan, DMD.

I have read the Financial Policy, and I understand and agree to the terms.

_____ _____

Print Name Social Security Number

_____ _____

Patient's Signature Driver's License Number

_____

Date