EAST END DENTAL ARTS FINANCIAL POLICY

Our office holds no contract with your insurance company. Your contract is between you and your carrier. **You are responsible for full payment if they deny charges.** We will however, submit insurance claims for you. **In order to process your claims effectively, we need updated information, such as identification numbers and group numbers, new insurance carrier and addresses.** We will ask to see your insurance cards repeatedly so we ask for your cooperation and patience. We are committed to providing the best treatment for our patients. We charge a fee that is commensurate with the services we provide. However, there are some charges that insurance companies do not cover, i.e. composite (tooth colored) fillings for teeth toward the back of the mouth, etc. **It is your responsibility to find out what is and what is not a covered service by your insurance company and your yearly maximum benefit.**

Some insurance carriers control their premiums by DECREASING benefits to the patient. An example of that would be, paying for bitewing x-rays only every 24 months. This does not change out protocol of taking x-rays once a year for proper diagnostic care. Dr Nelson makes these decisions based on what is **best for you**, his patient, **NOT** your insurance company.

If you do **not** have dental insurance, you will be responsible for 100% at the time of service. We do give a 5% discount as a courtesy when you **pay by cash or check on the day the charges are incurred**. We accept Discover, Mastercard, Visa, Care Credit and debit cards, **but if you are paying with a credit card there will be no discount.**

If parents are insuring their child/children under their insurance plan, then you the parents are agreeing to pay for those charges that insurance will not pay. Most insurance companies are allowing parents to insure a child/children until age 26. Until that point in time, you the parent(s) are responsible for the dental bill in our office.

New patients and a patient of record for less than one (1) year, your financial arrangements will be estimated and payment expected at time of service. This is done in an effort to build a mutual trust between dentist and patient providing you with the best care possible.

Signing this agreement indicates that you understand our office financial policy and will abide by it.

Sign_____ Date_____