Bridge City Dental

2427 Northgate Street, Ottumwa, IA 50201

FINANCIAL and SCHEDULING POLICIES

This agreement is between Bridge City Dental, PC as creditor and the patient/guarantor named on this form.

Payment/Insurance:

We require all patients to pay at time of service. We do not arrange payment plans. We will gladly submit your insurance claims and assist you in receiving the maximum benefit from your plan. All plans, however, have limitations and do not cover 100% of all our fees. Your contract with your insurance company requires you pay all applicable co-pays and deductibles. These fees must be paid to Bridge City Dental at the time of service.

It is your responsibility to know the requirements of your insurance company. This includes, but is not limited to: deductibles, co-pays, limitations, maximum benefits, waiting periods, pre-existing conditions and prior approval. Insurance contracts vary from company to company, patient to patient; so we may be unable to communicate all the details of your insurance plan with you. You may speak directly with your insurance company or your employer for this information.

Your insurance plan is based on a contract between your employer or a benefit group. It is not based on your individual dental needs. You are responsible for all charges your insurance does not cover.

Returned Check Fee: $35.00 to be paid and account brought current within 7 business days. We reserve the right to turn over the account to a collection agency and terminate the doctor / patient relationship if the account is not brought current within 7 days.

Divorce:

In the case of divorce or separation, the parent authorizing treatment for a minor will be the person responsible for the subsequent charges. If the divorce decree requires the other parent to pay all or part of treatment costs, it is the authorizing parent's responsibility to collect from the other parent. WE WILL NOT collect from them.

Past Due Accounts:

We will take necessary steps to collect any debt by means of a collection agency or attorney. If a patient refuses to pay charges, they may not be able to continue as a patient in this dental office. A finance charge will apply to any account balance that is over 60 days old.

Scheduling:

Every effort will be made to schedule your appointments at times that work for you. As a result, we ask you to show up to your appointments on time. If you need to reschedule an appointment, please give us 24-hour notice to do so. If a patient repeatedly misses appointments without providing proper notice, a $25 fee will apply. If a patient continues to miss appointments without notice we may not continue scheduling them at this office.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and this agreement will be in full force and effect.

Patient's Name: _____ DOB: _____

Patient's Signature (if minor, Guardian's signature) :_____ Date:_____

Responsible Party Signature:_____ Date:_____