Office and Financial Policy
Tanasbourne Family Dental

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

* You will need to provide our office with your social security number and health insurance card (if applicable) unless your total charge is paid in cash at time of service. Treatment may be postponed if the above are not furnished by the patient.

* All accounts are due and payable (including your percentage of the insurance coverage) at the time of your visit, unless satisfactory arrangements have been made with the Office Manager. These arrangements must be approved BEFORE treatment is rendered. Any balance outstanding more than 90 days will bear interest at 1.5% per month, which is 18% per annum.

* There will be a 5% discount for accounts paid in full on the day of service. This does not apply to credit cards.

* Insurance will be billed by the clinic as a courtesy. It is the responsibility of the patient to verify the the clinic has their correct insurance information and to inform them if there are any changes with their insurance provider. Insurance reimbursement is a contract between you, your employer and the insurance carrier. YOU are responsible for payment of your account.

* There will be a flat fee of $60.00 for any appointment NOT canceled within 48 hours of appointment. There will be a flat fee of $60.00 for NOT SHOWING for a scheduled appointment. We will not reschedule any patient after two missed or cancelled short notice appointments. Our time must be used as efficiently as possible to keep our expenses at a minimum and our fees within reasonable limits.

I have read this policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I understand that delinquent accounts may be assigned to credit reporting collection service and I will be charged a $50 collection fee. Also, if it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. This will ensure that our responsible patients will not be penalized to cover costs incurred by those who do not pay on time.

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Signature of patient or parent/legal guardian Date