

DR. SHERRY STEINMETZ



## No Surprise Financial Policy

When one is in the midst of being treated for a dental or medical concern, it is easy to forget that a health care office is also a business. In the interest of providing excellent dental care and doing good business, we believe it is best to establish a financial policy to avoid any misunderstandings. Therefore, we have developed the following financial policy:

***\*\*You are responsible for paying your bill\*\****

Even if you have dental or medical insurance our office cannot over-emphasize that insurance coverage and benefits have changed significantly over the years. We are happy to assist you in maximizing your insurance coverage in any way that we can. Please remember that your coverage is a contract between you and your insurance company. There is no way that our office can know the benefits of all the hundreds of different insurance plans. It is also impossible for us to keep track of when you have reached your insurance maximum, as many people have had work done outside our office by either a previous dentist or a specialist. We encourage you to be in contact with your insurance company directly.

***\*\*We require that you pay at or before your treatment visit\*\****

At the time of your routine dental cleanings, we will collect any co-pay your insurance requires and file all your insurance paperwork for you. In order to plan our time and treatment rooms effectively, we do ask for payment 3 business days prior to your appointments when you are having dental procedures (these would include fillings, crowns, periodontal therapies, smile designs, etc.). If you have any questions about this policy, please don't hesitate to ask.

***\*\*Missed appointment policy\*\****

Unless cancelled at least 2 business days in advance, our policy is to charge for missed appointments at the rate of \$50 per 30 minutes of appointment time scheduled. Please help us to serve you and all of our guests better by keeping scheduled appointments.

I agree to honor the policies outlined above. I agree to pay a \$10 monthly billing fee if my account is 30 days past due. I also agree to pay all reasonable costs of collection incurred if my account is not paid as agreed.

Thank you for understanding our No Surprise Financial Policy. Please let us know if you have any questions or concerns.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_