Steven St.Germain, D.D.S. Inc.

Patient Financial Policy

FINANCIAL POLICY

We appreciate having the opportunity to serve you and will make every effort to ensure you of quality dental care. We also strive to keep the costs to our patients as affordable as possible. In order to achieve these goals, we need your assistance and understanding of the following payment policy.

Based on the information you provide to us, we estimate your insurance co-payment which is due at the time services are rendered. We accept **CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND CARECREDIT.**

If you have dental insurance, we will be glad to file claims as a courtesy to you. Below is our policy on insurance.

- *It is **YOUR** responsibility to ensure that the insurance information we have on file is complete and accurate. We have no way of knowing when/if your insurance coverage changes.*
- *Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not with your insurance company. The filing of insurance claims is a **courtesy** we extend to our patients. All charges are **YOUR** responsibility from the date the services are rendered, whether your insurance company pays or not. Please remember that not all services are a covered benefit.*
- *Your co-payment is due at the time of service. Co-payments are estimated from the information your insurance company gives us. We are not responsible for actual payments made by your insurance carrier. After your claim is paid you may owe more money or have a credit that would be refunded to you.*
- *If your insurance company does not pay in full within 45 days, we may require you to pay the balance due.*

In the case of divorced parents, the parent who brings the child to our office will be deemed responsible for payment. Please do not put us in the uncomfortable position between any family disputes.

Any check returned to us by the bank due to insufficient funds will result in a $25.00 service charge to your account.

Sometimes insurance pays less than what we had anticipated. In those instances you, obviously, are responsible for the balance and will receive a bill. Bills are sent from our office on a weekly basis with a statement mailed to you billing address. Please let us know if your billing address changes. Payment is expected within 7 days.

CANCELLATION POLICY

As a courtesy, our office makes every effort to contact our patients to confirm appointments. It is your responsibility to keep all scheduled appointments. We ask for the courtesy of 48 hours notice if you are unable to keep a scheduled appointment. Appointments that are broken with less then 24 hours notice will be charged $ 35.00 for hygiene appointments and $ 50.00 for Dentist appointments. Failure to pay cancelled/missed appointment fees will result in dismissal from the practice.

ASSIGNMENT and RELEASE: I hereby authorize my insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for this claim of future claims. I authorize that my records may be used by the dentist if he so determines. If I am receiving dental hygiene services only, I understand that if any dental or medical problems are discovered during the course of my dental hygiene treatment, I will be referred to the appropriate dental or medical expert for any needed evaluation. In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with this Financial and Office Policy.

I certify that I have read or had read to me, the contents of this form.

Signature _____ Date _____

Parent or Guardian if minor