WARNER
DENTAL

Insurance and Financial Policy Agreement

Please read through and initial each paragraph

___**INSURANCE**: We submit claims to most insurance carriers. Please remember that insurance coverage is a contract between you and your carrier. You, the insured, are responsible for payment on claims that are 1) denied, 2) unpaid due to deductible, 3) partially paid, or 4) specifically partially paid due to the carrier's arbitrary determination of "usual and customary" rates. All balances are due and payable upon receipt. In-Network Non-Covered Charges: If you have an in-network insurance plan, there may be some services that are considered non-covered based on the insurance company. These non-covered services are deemed "Patient Responsibility" and will be an out-of-pocket expense.

___**CONTACT INFORMATION**: You agree that, in order for us to service your account or to collect payment you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you via text message or e-mail, using any e-mail address you have provided.

___**PAYMENT**: Fees for routine dental services (examination, cleanings and x-rays) are due in full on the date service is rendered unless previous arrangements have been made with the office manager. This includes co-pays, deductibles, out-of-pocket expenses, and other fees deemed "Patient Responsibility."

___**MAJOR PROCEDURES**: All major procedures requiring over 2 hours, such as crowns, bridges, dentures, partial dentures, root canal therapy, root planing, or extensive general dentistry may require full prepayment /insurance co-payment to reserve your spot.

___**MINOR PATIENTS**: Parents must accompany minor patients to their appointments. For unaccompanied minors, non-emergency treatment may be denied without proper insurance documentation or payment arrangements.

___**CANCELED OR FAILED APPOINTMENTS**: We understand that from time-to-time emergencies arise which may require that you miss a scheduled appointment. However, our time and our other patient's time is valuable. Because we have reserved time specifically for you, we politely request that any changes to an appointment time are made at least 24 hours in advance. This allows time for our office to attempt to fill the vacancy. A history of last-minute cancellations or failed appointments may result in a down payment being required to hold your next appointment. Missed appointments, and appointments canceled within 24 hours of the scheduled time, will incur a charge of $125 per hour. This applies to prepaid appointments as well.

___**DELINQUENT ACCOUNTS**: Delinquent balances (when any balance owed is not paid within 120 days from treatment and no other financial arrangements have been made) will be forwarded to a collection agency after all reasonable attempts to collect have failed. To remain an active patient, it will be expected that you pay all collection fees incurred. You may also be required to prepay for future appointments.

___**COLLECTIONS**: If collections become necessary, you agree to pay an additional collection fee of up to 40%, and all legal fees, including attorney fees and court costs. You also understand and agree that a collection agent may be sent to your place of residence or work to deliver any necessary collection documents.

___**MEDIATION**: Should any claim or controversy arise between you or your legally authorized representative and our practice concerning the care and treatment rendered to you by our dental team, an effort shall be made by the parties involved to resolve the dispute through mediation appointed by Professional Insurance Exchange, should the dispute pertain to the quality of the dental services rendered. Costs for the mediation services shall be shared equally by the parties involved. This mediation agreement does not pertain to actions taken for the collection of debts owed, as noted above.

Signature

By signing below, I acknowledge that I have read, understand, and accept this Financial Agreement in its entirety.

Printed Name of Responsible Party	**Signature of Responsible Party**	**Date**