ProDent Care
Modern Dentistry with a Caring Touch

Financial & Payment Policy

Print Form

Thank you for choosing us as your dental provider. We are committed to providing you with quality and affordable dental care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Payment for service. Payment is due at the time of service unless other arrangements have been made. We gladly accept Visa, Master Card, personal checks or cash. Ask us about other financial arrangements available.

2. Insurance. We participate in most dental insurance plans. If you are not insured by a plan that we are a provider for, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

3. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Non-covered services. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by your dental plan. You must pay for these services in full at the time of visit.

5. Proof of insurance. All patients must complete our patient information form before seeing the dental provider. To confirm your insurance eligibility, please provide us with a copy of your driver's license and current valid insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

6. Claims submission. As courtesy to you we will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. Coverage changes. If your insurance changes, please notify us immediately so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance may automatically be billed to you.

8. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative dental care. During that 30-day period, your dentist will only be able to treat you on an emergency basis.

9. Missed appointments. Our policy is to charge a fee equal to $50 for missed appointments NOT canceled or rescheduled prior to 48 hours of your scheduled appointment. This will allow more availability for patients who desire to be seen. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

10. Returned Checks. All returned checks will be subject to an external collection service and a collection fee of $25. In addition, to cover the cost for returned checks, you will be charged an administrative fee of $25 (which includes the bank penalty charges incurred) and the cost of certified mailing in the addition to the amount of your returned check amount.

11. Credit Balance. If there is a credit balance on your account, we will mail you a refund check within 30 days.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read the above. I fully understand and accept the terms and conditions set forth.

Signature of patient or responsible person: _____

Print Patient Name: _____ Date: _____

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