Advanced Family Dental
12758 Boenker Lane
Bridgeton, MO 63044
314.739.3300

FINANCIAL POLICY

Thank you for choosing us to meet your dental needs. We have found that once firm financial arrangements have been established, dental care can proceed in a timely, orderly fashion. Our office needs to know the method of payment you will be using to pay for your portion of dental treatment rendered to you and your family. Unless financial or insurance arrangements have been made in advance, payment for treatment rendered is expected in full at each visit. If you have dental insurance you will normally have a deductible and co-pay for all treatment. You should be prepared to pay these at every appointment.

Please indicate how you plan to pay by placing a check mark in the appropriate box and initial it:

- ☐ Cash _____Initial
- ☐ Check _____Initial
- ☐ Credit card or debit card. _____Initial
  We accept MasterCard, Visa, Discover and American Express. If you plan on using a credit card please enter your card type and number:
  Type_____Number_____

  Expiration Date:_____

We believe that all patients deserve quality care. Regardless of the type of dental benefits you have, we treat all patients. We participate in some but not all PPOs and all indemnity insurance plans. We **do not** participate in HMO's. We **do not** take Medicaid. This does not mean that we will not treat you. It simply means that you will have more out of pocket expenses.

For billing purposes and convenience, we request a credit or debit card account to cover your balance on treatment that has been rendered and not covered by any dental insurance due to your insurance limitations, maximums, fee schedules and incorrect benefit information your insurance company may supply us.

We will bill your credit or debit card any balance once we have received notification from your carrier that they have processed your claim. If you desire to limit the amount billed, you will need to use the financing we offer and/or speak with our office manager.

☐ I desire to limit the amount billed to my credit/debit card. _____Initial
Please enter dollar amount limit _____. (If this option is chosen you will need to make financial arrangements **prior** to treatment starting.)

☐ I do not wish to use a credit/debit card. (If this option is chosen you will need to make financial arrangements **prior** to treatment starting.)
_____ Initial

As a courtesy, we will submit all insurance for you. Your insurance company **does not** guarantee payment. You are responsible for the cost of all treatment rendered. If you desire to file your own insurance, please let us know. We will print the claim for you and you may submit it. You will receive payment directly.

☐ I plan to submit my own insurance. If I choose to do this I will pay for any treatment rendered at each appointment. _____Initial

☐ I assign submission and benefits to Advanced Family Dental. Regardless of insurance payments, I understand I am responsible for the costs of all treatment rendered. _____Initial

We electronically file insurance the same day you're treated. We then give you a service fee grace period of 45 days. After this period, any balance you have will incur a monthly service fee of 2%. _____Initial

If your account is turned over to a collection agency or attorney, you will be responsible for any collection fees and court costs. _____Initial

I have read and understand all of the above. I have had any questions that I may have had answered. I am responsible for the cost of all dental treatment rendered regardless of any insurance coverage. I will contact my insurance company or personnel department if I have any questions regarding my policy.

Patient signature _____ Date_____
(Guardian signature)