FINANCIAL POLICY

In order to keep our fees down and provide quality dental care with the latest in sterilization techniques and dental procedures, we have established the following financial policy:

Payment is expected in full on the day of service by cash, check, debit, or credit card.

Dental Insurance: Estimated Co-payments (the part of dental fees not covered by your insurance and deductibles) are due on the day of service. You must provide a completed dental form with assignment of benefits to the doctor.

Laboratory Dental Procedures: For all laboratory dental procedures (crowns, bridges, partials, dentures, etc.) a retainer fee of half of the cost of the procedure is due on the day impressions are taken. Patients with insurance must pay their co-pay the day impressions are taken.

Payment Plans: Payment Plans are not generally offered. On large treatment cases financial arrangements may be considered by the doctor only and shall be discussed before the first treatment visit.

Children: The parent or guardian who brings the child into the office for treatment is financially responsible regardless of dental insurance or legal responsibility another parent or guardian may have to this child.

TMJ: For all procedures concerning TMJ issues payment in full must be received when treatment begins regardless of insurance. We will be glad to assist you in filing for the insurance company to reimburse you.

Missed Appointment Charge: If you are unable to keep your appointment, we require at least 24 hours notice to avoid a charge for our lost time. The fee for missed appointments will be determined by time allotted and number of missed appointments.

Finance Charge: If your entire balance is not paid by the 15th of the month following billing date, a finance charge of 1.5% on the balance then unpaid and owed will be assessed each month.

PATIENT AGREEMENT

I have read the above policy and understand my financial responsibility.

I have completed this form and to the best of my knowledge all answers are true and correct.

If I ever have a change in my health, medications, address, employer, or insurance, I will inform the doctor or office manager at the next appointment.

I give permission for a credit history report to be obtained.

I accept full responsibility for all fees regardless of dental insurance.

I realize that failure the keep this account current may result in you being unable to provide additional dental services except where there is prepayment for the services.

In any event this account is referred to an outside agency, credit reporting bureau, or attorney for collection, I agree to pay all attorney fees, collection costs, court costs, and/or any other expenses incurred in its collection, according to the statutes of the State of Tennessee.

I hereby authorize Dr. Balkon to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the doctor all payments for dental services rendered to my dependents or myself. I understand that I am responsible for any amount not covered by insurance.

Signature of Patient, Parent or Guardian: **Date:**