Financial Consent for Services

Our office financial policy is a **FEE FOR SERVICE** practice. For patients with no insurance, this means that the full cost for the dental visit will be due on the date of service. We accept payment via cash, check and credit cards. We also accept a third-party payment option through Care Credit. This third-party payment option is an agreement between you and Care Credit and not Dr. Moore.

For patients with insurance, we will file the insurance claim. If an insurance company charges a processing fee to process a claim for the patients, this fee will be the responsibility of the patient. If the insurance company requires the claim check to go to the subscriber, full payment will be expected at time of service. CO-PAYMENTS, PATIENT'S PORTION FOR TREATMENT AND PRIOR OUTSTANDING BALANCES ARE DUE ON THE DATE OF SERVICE. When calculating your ESTIMATED co-payments and patient's portion, we use the information obtained from your insurance company/companies. Please be aware that you are financially obligated to pay the portion of your bill that the insurance does not pay or cover.

A FEE OF $100.00 PLUS ANY BANK CHARGES WILL BE APPLIED ON RETURNED CHECKS.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash, or credit card at the time of services. Out of town residents are required to pay in cash or with a credit card and the insurance payment will be sent to the subscriber.

If after 30 days **from the date of service,** there remains an outstanding balance (including outstanding insurance payments), a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $3.00), which is an annual percentage of 18%.

Once you receive your first bill, please call our office to pay on your account.

A) IF YOUR ACCOUNT IS NOT PAID IN FULL BY THE STATEMENT DUE DATE, THERE WILL BE AN ADDITIONAL $15.00 FEE ADDED TO YOUR ACCOUNT BALANCE FOR EACH ADDITIONAL STATEMENT MAILED.

B) IF THERE IS AN OUTSTANDING BALANCE ON THE ACCOUNT AFTER 60 DAYS, COLLECTION PROCEDURES WILL BEGIN.

C) IF THE OUTSTANDING BALANCE ON YOUR ACCOUNT IS NOT PAID IN FULL WITHIN 75 DAYS OF YOUR DATE OF SERVICE, YOUR ACCOUNT WILL BE FORWARDED TO COLLECTIONS. YOU WILL INCUR ADDITIONAL FEES WHICH INCLUDE THE INTEREST ON THE BALANCE, COLLECTION FEES AND REASONABLE ATTORNEY FEES OR EMPLOYEE COSTS.

If you need to change your appointment, we will be happy to find a more convenient time for you. This requires at least 1 BUSINESS DAY'S NOTICE (WHICH DOES NOT INCLUDE WEEKENDS). If you do not show up for your appointment time, you may be charged at a rate of $100 PER HOUR WITH A MINIMUM OF $55.00. Your dental care is important to us, as well as the dental care of all our other patients.

I UNDERSTAND THE ABOVE AND AGREE TO ITS TERMS

____ Date: _____________Relationship to Patient:_________________

Print Patient Name

____ Date:_____________Relationship to Patient:_________________

Signature of guarantor of payment/responsible party