

Springcrest Dental Associates
Financial Policy

Thank you for choosing us as your healthcare provider. The following is our Financial Policy. Our main concern is that you receive proper and optimal treatments needed to restore your dental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to contact our office staff. We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, Mastercard, American Express and Discover. For your convenience, we do offer financing through Care Credit. We will be happy to help you process your application and your insurance claim for your reimbursement as long as you bring the required information to each visit. Most insurance plans are payment assistance plans; they are not designed to cover the entire costs of treatment.

Our financial policy is as follows:

1. We bill most insurance plans as a courtesy to you. Your deductible and/or co-payment for our services is due in full at time of treatment.
2. Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. Any disputes with your insurance company are your responsibility.
3. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Fees for these services, along with unpaid deductibles and co-payments are due at the time of treatment.
5. If the insurance company does not pay after 90 days, we require you to pay the balance due with cash, check, or credit card.
6. Returned checks will be subject to additional fees.
7. All balances over 90 days will be reviewed and turned over to an agency for payment or will be sent to our Legal Counsel. You will be responsible for any additional charges incurred.
8. We reserve the right to charge a fee for broken appointments.

We understand that temporary financial issues may affect timely payment of your account. We encourage you to communicate any such problems so that we may assist you in the management of your account.

Patient Signature: _____ Date: _____