Bullis Pond Dental
DR. CF TRAVIS
PREVENTIVE CARE • SMILE DESIGN • RESTORATIVE CARE

FINANCIAL POLICY

At Bullis Pond Dental we want you to feel comfortable with your dental care and that includes feeling satisfied with your financial arrangements. If you have any questions or concerns with this Financial Policy please do not hesitate to ask our business staff.

For routine appointments such as cleanings, exams, or any dental work, your complete payment is due on the day of service. If you have dental insurance, only your patient co-pay is due on the day of service.

DENTAL INSURANCE: As a courtesy we will gladly file your claims and accept assignment of dental insurance benefits provided you agree to the following:

- Although we may estimate your insurance benefits we are not responsible for their accuracy. Knowledge of benefits as well as benefit amounts, limitations, exclusions, waiting periods, etc. is entirely your responsibility. Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- All charges not paid by your insurance are your responsibility regardless of the reason for nonpayment. Not all the services we provide are covered benefits. Benefits differ from one company to another. Fees for non- covered services along with deductibles and co payments are due at the time of treatment.

PATIENTS WITHOUT DENTAL BENEFITS: We provide written estimates of fees and payment is expected at each visit for services rendered.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for full payment. In the case of divorced or separated parents, the accompanying parent is responsible. This office will not attempt to collect payments from a parent that is not present at the office visit.

OVERDUE BALANCE: We understand temporary financial problems may affect timely payment of your balance. In those situations we ask that you communicate with us immediately so we may assist you in the management of your account. If there has been no communication concerning an unpaid balance after 90 days it will be sent to a collection agency.

We request your signature below affirming that you understand and agree to the financial policies of Bullis Pond Dental

_____ _____/_____/_____

Signature of Patient or Account Guarantor *Date*