

## FINANCIAL POLICY

We welcome and encourage frank discussion of services and our fees prior to treatment in order to avoid misunderstandings. **Our financial policy requires payment or estimated copayment in full at time of service.** We accept Cash, Visa, MasterCard, American Express and Discover as methods of payment.

**BILLING:** There is a \$25 charge to accounts for all bank returned checks that have nonsufficient funds. Please be advised there will be a \$5.00 REBILL fee and interest charges of 1.50% applied to any accounts on delayed payments. Accounts overdue will be subject to collection procedures. Any account sent for collections will assess an additional \$100 processing fee. **If the account should become delinquent, patient agrees to pay for all rebilling charges, interest charged, collection costs and attorney fees.** We consider financial matters important and ask you bring any concerns to our attention.

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Signature of **PATIENT** financially responsible for account

Date

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Signature of **PARENT** accompanying minor child-account holder

Date

**INSURANCE:** We will do our best to verify any insurance coverage you may be eligible for however the financial obligations for the treatment we render to you are **your** responsibility. For many of you, your insurance is a contract between you and your employer and we are no a party of that contract. For some of you, we are a contract provider with your insurance company and that contract states that we will agree to lower our fees for service from our regular set fees for those patients with those insurance company benefits however does not remove you from your primary obligation. We are happy to assist you in submitting claims to your carriers for consideration. After our office has received payment from your carrier(s) and any/all applicable adjustments have been made, **your remaining balance** will be billed to you and is then **due and payable upon receipt**. You may also have a credit balance after all insurance payment are posted. All credit balances are issued around the 5<sup>th</sup> and 25<sup>th</sup> of each month.

I authorize release of any information relating to this claim. I hereby authorize payment of any insurance benefits due to me to: Brad Mayerle, DMD and Ian Tydeman, DMD. A copy of this authorization is valid.

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Primary Insured Employee

Date

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Secondary Insured Employee

Date

Secondary Insured Employee Date **PATIENT INFORMATION:** Please understand your patient information is held in confidences and that no information will be given out without your signed consent. By signing this form it gives us permission to use your information solely for the purpose of collection of your claims.