

**FINANCIAL POLICY**

We accept many different insurance plans. Not all insurance plans have the same coverage. **It is your responsibility as a patient to know what your plan covers.** While discussing your treatment plan with your provider, ask questions if you are not sure if a procedure is covered. Make sure you are aware of all procedures that are about to be rendered.

Some common procedures that vary among insurance plans are:

- Sealants       Fluoride treatments       Time in between cleanings
- X-rays       White (resin) posterior (back) fillings       Arestin / Sedative fillings

**As a patient at Dr. Jan P. Fugal’s practice, I accept responsibility for knowing the benefits (coverage) of my insurance plan. I also accept responsibility for any fees incurred from treatment rendered that my insurance plan will not cover.** \_\_\_\_\_(Initials)

For any services that are rendered that include lab work (crown, bridge, nightguard, bleaching trays, etc.) ½ of co-payment will be do at the initiation of treatment and the remainder will be due upon delivery / completion of treatment. \_\_\_\_\_(Initials)

As a courtesy to you, our practice will be happy to submit your claims to your primary dental insurance. Please fill out the Patient Insurance form. Please present any new dental insurance cards so that we may update your records along with any changes to your residence or phone number(s).

We collect an ESTIMATED copay at time of service. All payments not received by the due date of a subsequent bill will be assessed a \$30 late fee. We utilize the assistance of a collection agency in pursuit of unpaid balances that we are unable to resolve equitably. Please be aware that if an agency is used, the cost of the agency services will be passed along to you, resulting in the inclusion of a 33% service fee. \_\_\_\_\_(Initials)

Please note that any checks that are returned by your bank, for any reason, will result in a return check fee of \$30.00 plus the outstanding balance. \_\_\_\_\_(Initials)

If you are unable to keep the appointment you have scheduled, please notify us at least 24 business hours in advance. We make an effort to confirm your appointments; however we are not always able to do so. Please be aware of your appointments and call us to confirm them 2 days ahead if you have not heard from us. We would be glad to reschedule any appointments at a more convenient time, if necessary. If you fail to give cancellation notice at least 24 business hours in advance, you may be charged a broken appointment fee. \_\_\_\_\_(Initials)

**Fees are subject to change without prior notice.**

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION THAT HAS BEEN GIVEN TO ME. BY MY SIGNATURE BELOW, I CONSENT TO THESE TERMS.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date