Bear Family Dentistry Financial Policy and Consent

Thank you for choosing Bear Family Dentistry to serve your dental needs. Our office is dedicated to providing the highest quality of dental care possible for every patient. The following is a statement of our financial policy. Please read it and let us know if you have any questions.

***** All estimated fees are due at the time of service.*****

Non-Insurance Patients:

_____I understand that I **DO NOT** have insurance coverage and select to be self-pay. Payment is due on the day that dental procedures are performed. For your convenience we accept cash, personal checks, money orders, debit cards, all major credit cards, and Care Credit.

Insurance Patients:

I understand that I **DO HAVE** dental insurance and that Bear Family Dentistry will file my insurance as a courtesy and that there is no guarantee of coverage. Patient portions are an estimate and not a guarantee of exact payment. The patient is responsible for the estimated portion of the procedures and deductibles at the time of service. Once your insurance company has paid, you will be responsible for any balance that is remaining. If your insurance policy pays you directly, you are responsible for the amount they pay and your portion.

_____ I understand that my insurance is **OUT OF NETWORK** with my chosen provider. Procedures are quoted at standard fees and I am provided with an estimate of my out of pocket according to my insurance policy. This is not a guarantee of benefits and I accept responsibility for payment of services.

_____ I understand that my insurance is **IN NETWORK** but the benefits may not cover all services according the estimate given. I am responsible for deductible and my patient portion at the time serves are rendered and any balance after my insurance has paid.

Late Arrivals/No Shows/ Same Day Cancellation:

- When our office books your appointment we are setting aside a dedicated chair and time slot just for you. We require at **LEAST a 24 hr. verbal notice** with one of our staff to cancel or reschedule an appointment.
    - A **$50** fee will be charged for same day cancellation.
    - A **$75** fee will be charged for same day cancellation on high production appointments or **15%** of the total procedure amount.
- If you arrive **15 mins. LATE to your appointment,** you have missed your appointment; therefore a **$25** late cancellation fee will be charged, whether you are seen or not.
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*****Please initial that you understand the fees above, if you have any questions please ask us.**_____

Returned Checks:

The charge for a NSF (non-sufficient funds) check is $35.00. You must pay the full amount for the NSF check and the $35.00 fee within 14 days of notice. The balance cannot be paid with another check and no future checks will be accepted as payment for future treatment. If payment or an arrangement of payment is not received by the due date, we will pursue other collection actions.

I have read, understand and agree to all of the above. I have been given the opportunity to ask questions. If I have insurance, I hereby authorize my insurance company to pay my dental benefits directly to Bear Family Dentistry, and I authorize Bear Family Dentistry to release any medical information to my insurance company as needed to process my claim(s).

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Signature of Patient/ Responsible Party Date