

Osprey Dental, LLC

FINANCIAL POLICY

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment. **Payment is due at the time service is provided.** Our office accepts cash, personal checks, credit cards and outside patient financing. Please check if you would like more information about financing options. **Please Note:** Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges up to 35%. **Do You Have Insurance? We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company.** As a courtesy to you we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however, it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits will determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. **If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.** We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, credit card or Patient Financing at the time we provide the service to you. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim. We thank you for the opportunity to serve your dental health care needs and welcome any question you may have concerning your care or our financial policy.

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge and/or attorney fee will be added to any overdue balance. By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose. You agree to any fees or charges that you may incur for an incoming call from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.

Patient Name Printed:	Date:
Patient Signature (Parent if Child):	Date:

APPOINTMENT POLICY AGREEMENT

Osprey Dental is dedicated to your quality care and is pleased to reserve your appointment time exclusively for you. For appointments requiring a reserved time of 3 hours or more, prepayment will be required at time of scheduling.

Osprey Dental reserves the right to charge \$50 for any missed, cancelled, or rescheduled appointment within 48 hours of the appointed time.

Thank you for understanding and respecting our time policy!

I have read, understand and agree to abide by the practice appointment policy.

Patient Name Printed:	Date:
Patient Signature (Parent if Child):	Date: