

# Ahwatukee Dentistry, PLLC.

## FINANCIAL POLICY FOR ALL PATIENTS

Responsible parties, please initial

\_\_\_\_\_ If you are covered under a dental PPO, POS or Indemnity policy, it is your responsibility to provide our office with your insurance plan information, subscriber number and your insurance card. If you have not been seen or treated by Dr. Le or her staff prior to this visit, your dental insurance needs to be verified. Should you NOT have your insurance card or any information on your insurance you need to be rescheduled for the visit or pay in full of services rendered at the time of service.

\_\_\_\_\_ There will be a \$35 charge for all returned checks due to any reason. Writing bad checks is further prosecutable by laws in the state of Arizona.

\_\_\_\_\_ Your insurance deductible, co-insurance and co-payments will be collected at the time of visit and we will bill your insurance company for the balance. After your insurance has paid in full portions of the claims, the remaining balance, if indicated, will be your responsibility and is due promptly within thirty (30) days from the billing date.

\_\_\_\_\_ If we are not contracted with your dental insurance plan, we are able to bill any balances to the patient, guardian/parent that has been denied or has not been paid by your insurance plan.

\_\_\_\_\_ For minor patients or those covered under a family member's insurance policy, all applicable charges are the adult guardian/parent's responsibility. Parents acknowledge and accept all charges if the dental insurance company denies all or part of the claims for the services rendered to the parent's.

\_\_\_\_\_ Any outstanding balance is considered delinquent after forty five (45) days from the billing date of your first (1<sup>st</sup>) bill or ninety (90) days from the date of service. Unpaid balance will accrue interest sixty (60) days from the date of the service. Failure to properly pay the remaining balance will result in your account being sent to a collection agency. Once your account has been sent to a collection agency, they will be additional collection charges of 50% over outstanding balance if an attorney is involved in the settlement of your account, there will be additional charges as well as all expenses incurred for collection/legal services will be your responsibility.

I authorize the release of dental/medical or other information necessary to process the claims for my account or my dependent's dental treatments. I further request and authorize payment of government and private insurance dental benefits to the undersigned dental provider of services rendered to myself or my dependents.

\_\_\_\_\_  
Patient/Guardian/Patient Signature

\_\_\_\_\_  
Date