



HILLSTREAM DENTAL

Financial Policy Form

Dear Patient:

Thank you for choosing Hillstream Dental to service your dental care needs. It is our privilege to be your dental health care provider and we appreciate the trust that you have given us. We are committed to provide only the best dental care. In order to give you the best experience possible, we have found that when everyone is clear on payment for treatment, then confusion and misunderstanding is kept to a minimum.

The following is our Financial Policy. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our payment policies please do not hesitate to contact our office staff. We ask that all patients read and sign our financial policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, personal checks, and for your convenience, MasterCard, Visa, Discover, and American Express. We also offer Monthly Payment Plans. We will be happy to process your insurance claim for you at each visit.

In some instances we may accept assignment of benefits. Please ask the office staff if we participate with your insurance carrier. However, you must understand that if we do not participate with your insurance carrier:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.
2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. This does not mean it is not the treatment you need.
3. Fees for these services, along with unpaid deductibles and co-payment, are due at the time of treatment. If payment arrangements have to be made, this must be done before treatment and approved by the office manager.
4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the insurance carrier to help speed things up.
5. **If the insurance company does not pay your balance in full within 45 days, we require you to pay the balance due with cash, personal check, MasterCard, Visa, Discover or American Express.**
6. Returned checks will be subject to a \$25 collection fee.
7. All balances older than 60 days will be reviewed and turned over to collection.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we assist you in the management of your account.

We also understand that dental care can be costly; therefore, we do our best to keep our fees as low as possible. We appreciate your assistance in helping to keep our costs to a minimum by taking care of your financial obligations when services are rendered. **We respect your time, please respect ours. To avoid a missed appointment fee, we require at least a 24-hour notice.**

Again, thank you for choosing Hillstream Dental as your dental healthcare provider. We appreciate your trust and we appreciate the opportunity to serve you.

Patient's name (print): _____ Date _____

Patient's signature: _____ Date _____

Patient's guardian: _____ Date _____