

FINANCIAL POLICY FORM

DR. ROD ELLISON, D.D.S.

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Our provision of care to you will result in a bill for our services. Following is a statement of our financial policy, which we request you read and sign prior to your treatment. In addition all patients must provide basic registration and insurance information before seeing the Doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS WE ARE BILLING YOUR INSURANCE FOR YOU, IN WHICH CASE, ANY APPLICABLE CO-PAYMENT OR DEDUCTIBLE IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA/MC OR CARE CREDIT.

REGARDING INSURANCE

We ask that you show us a copy of your dental insurance card at the time of each visit so we can set up the correct billing information. As a courtesy we will bill your insurance carrier for the charges which the company has agreed to pay. You are responsible for any amounts not covered by your insurance, including co-payments and deductibles. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you do not inform us of any special requirements or guidelines in your policy, such as second opinions, pre-authorizations, preferred providers and covered and non-covered services, and we subsequently perform or order items or services that are not covered we will have to bill you directly for those charges. If your insurance company has not paid your account within 45 days, the account automatically becomes your responsibility and will become due immediately. Please be aware that some of the items or services provided may not be covered or may not be approved for payment under your policy, but have been deemed to be in your best interest by your Doctor.

RESPONSIBILITY

If you are 18 or older, you are legally responsible for your own account, regardless of who you come with, who has a contract with an insurance company or who claims you as a tax deduction. If the patient is under 18, both parents, despite divorce or other separating arrangements, or the legal guardian of the patient, are responsible for payment.

I have read the Financial Policy and understand and agree to its terms.

Signature of patient or responsible party

Date: _____