Payment/Copays/Deductibles

Payment for co-pays and/or deductibles is due at the time services are provided. We have several options for payments of services, which may be paid in the following manner:

1. Payment by cash, Visa, MasterCard or Discover Card.
2. Payment by CareCredit. Care Credit is banking for qualified applicants who prefer additional time to pay their balance. It is a revolving line of credit through an independent financial institution. It is designed to meet the needs of our patients and is ideal for extended treatment plans, elective procedures, emergency care and treatment not covered by insurance. Care Credit has financing options available that include six (6) month interest free payment plans, as well as an extended payment plan.

I/We understand the above paragraph regarding payment for services, and have had the opportunity to have any questions answered to the best of Dr Camman's and her staff's ability.

_____Signature of Responsible Party _____Date

Account Balances/Charges

A returned check fee of $45.00 will be applied to your account for any personal check returned unpaid or with non-sufficient funds. Balances older than ninety (90) days will be subject to an additional billing charge of $5.00. Any balance older than 90 days will be subject to interest charges of 1.5% per month until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency and additional collection fees will be applied to any unpaid balance. Any attorney or collection fees incurred due to delinquency in payment will also be charged to the patient. We do understand that temporary financial problems may affect timely payment of your account. If this is a concern we do ask that you contact us promptly for assistance in the management of your account.

I/We understand the above paragraph regarding payment for services, and have had the opportunity to have any questions answered to the best of Dr Camman's and her staff's ability.

_____Signature of Responsible Party _____Date

Cancellations and Broken Appointments

In an effort to keep dental costs down while maintaining a high level of professional care, we respectfully request a 48 hour cancellation notice. Your scheduled time has been saved only for you and the doctor and/or hygienist. Due to staff overhead that occurs in broken appointment slots, a cancellation fee is charged if a 48 hour notice is not given. Our message system will accept your cancellation calls for you and will record time/date of your call to avoid a $50.00 charge to your account. We appreciate your efforts to keep scheduled appointments and we will make every effort to continue to have convenient hours and prescheduled appointments availability for you.

I/We understand the above paragraph regarding payment for services, and have had the opportunity to have any questions answered to the best of Dr Camman's and her staff's ability.

_____Signature of Responsible Party _____Date

FINANCIAL POLICY
DR CONSTANCE CAMMAN, D.D.S.

_____

(Patient name)

We welcome you and your family to the office of Dr Constance Camman. We look forward to providing you with the most exceptional dental care. To provide you with the most beneficial and comprehensive service and care, we do ask that you review and complete our office financial policy and consent forms. We strive to keep you informed and involved with your treatment as much as possible.

DENTAL INSURANCE

_____(initials) I/We DO NOT have dental insurance

_____(initials) I/We DO have dental insurance (if so, please continue below).

If you have dental insurance, we will file the claims for you, as a complimentary service. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim and collect payments. If this information changes, it is the patient's responsibility to update our office. We do accept payments from the dental insurance companies; however, we are not contracted with them. It is a contract between you, your employer and the insurance company.

Our staff will provide you with an ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are STRICTLY ESTIMATES and not a guarantee that your insurance company will reimburse us/you according to these estimates. It is possible that we could preauthorize any treatment to verify plan coverage and benefits. The turnaround of this information from your insurance company is usually thirty (30) days.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. We emphasize that as dental care providers, our relationship is with you, NOT your insurance company. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after sixty (60) days from the date of service becomes the immediate responsibility of the patient and/or account holder.

PAYMENT FOR SERVICES (YOUR COPAY/COINSURANCE) IS DUE AND COLLECTED AT THE TIME THE SERVICES ARE PROVIDED.

I/WE UNDERSTAND THE ABOVE PARAGRAPH REGARDING DENTAL INSURANCE, AND HAVE HAD THE OPPORTUNITY TO HAVE ANY QUESTIONS ANSWERED TO THE BEST OF DR CAMMAN'S AND HER STAFF'S ABILITY.

_____Signature of Responsible Party Date_____

_____ Witness Date_____