FINANCIAL POLICY

Thank you for choosing Harvest Family Dentistry for you and your family's dental care needs. We are committed to your dental treatment being successful and pleasant. It is our policy to make definite financial arrangements with you prior to your treatment visit. The following is an explanation of our payment procedures and office policies. If you have any questions, please do not hesitate to ask.

1. Payment is due at the time of the services. We accept cash, checks, Visa, MasterCard and Discover.
2. Cash specials (does not apply to insurance plans) 5% on treatment between $750-$1000 and 10% on treatment $1000 and up.
3. Return checks: If a check is returned for any reason there will be a $35 return check fee. From that point on checks will not be accepted but you can pay with cash or credit cards.
4. The parent or guardian who brings the child will be responsible for payment regardless of what the divorce decree may say. Reimbursement must be made between the divorced parents. We will not intervene
5. Cancellations: If you are unable to keep your appointment and cancel the day of the appointment or just don't show you could be subject to a $30 fee for every hour on hygiene and a $50 fee for every hour on the doctor's books.
6. Our policy is to forward any unpaid accounts to an attorney, collection agency or credit bureau for processing as a bad debt. If this occurs you will be required to pay the associated legal fees.
7. Any account that is not paid in full in 90 days will have an added monthly 1% finance charge and $2.00 monthly billing fee. This will incur monthly until the balance is paid in full.
8. Emergencies: We require payment in full at the time of the appointment.

INSURANCE:

Insurance is not as easy to understand as it used to be. It is wonderful to have but it is ultimately YOUR responsibility to understand how it pays for services. We encourage you to check with your insurance company and /or employer to determine your specific coverage. Our fees are not based on what your insurance company pays. Our top concern is treating you and your family not your insurance company. We consider it a service to you to file your insurance. We do require payment of any **ESTIMATED** deductibles and portions at the time of service. We must have complete and current up to date insurance information in order to bill your insurance on you r behalf. In an event that your insurance has not paid their portion in 60 days the balance then becomes your responsibility.

PRE-ESTIMATES:

If you would like to know exactly what your insurance will pay on services we can submit a pre-estimate. This may take 4-6 weeks to receive a response from your insurance company. Most insurance companies will let you know that "this is only an estimate, not a guarantee of payment or coverage". Pre estimates are only sent if you request it of our financial department.

NON COVERED SERVICES:

Our doctors recommend what is best for your dental health. None of our recommendations are based on what your insurance does or does not pay. Any service not paid for by you insurance is your responsibility.

SECONDARY INSURANCES;

Most all insurances no longer coordinate benefits. What this measns to you is that your second insurance will only pay up to up to the amount that they would have paid if they were your only insurance. The only way you would receive secondary benefits is if your second insurance pays some better than your primary or if your primary has limits or is maxed out. Having two insurances does not mean that you will receive up to 100% coverage. If you have any questions concerning two insurances please see our financial coordinator.

PPO Insurance:

We are a provider for BCBS of AL, Delta Dental, Guardian, Metlife, Aetna, Ameritas, Cigna, GEHA, United Healthcare Southland, Blue Dental, United Concordia, Dentamax and Principal. In order to accept your insurance under the PPO circumstances, we ask that you be prepared to pay any copays or estimated portions before dental services are rendered. Please be aware that this is AN ESTIMATE only. Coverage may be different if your deductible has not been met, annual maximum has been met or if your coverage table is lower than average. Treatment plans expire one year from the printed exam date

AGREEMENT TO PAY:

I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection agency fees, (33.33%), attorney fees and /or court costs, if such should be necessary.

I, the undersigned, agree, in order for us to service your account or to collect monies you may owe Harvest Family Dentistry and /or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide for us to use. Methods of contact may include using pre-recorded /artificial voice messages and /or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Harvest Family Dentistry, its employees and /or agents may contact me/us as described above. I have read this form and I had the opportunity to ask any questions. I agree to the terms and conditions of this agreement. No modifications apply to this document.

Signature _____

Print Name(s):_____

DATE _____

Relationship to patient _____